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Supreme Court, U.S.
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In the
Supreme Court of the United States

OCTOBER TERM, 1992

FLORENCE B. CORCORAN, WIFE OF/AND
WAYNE D. CORCORAN

Petitioners

v.

UNITED HEALTHCARE, INC.
AND BLUE CROSS AND
BLUE SHIELD OF ALABAMA, INC.

Respondent

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether § 514(a) of the Employee Income Security Act ("ERISA"), 29 USC § 1144(a), preempts state law causes of action for the wrongful death of an unborn child based on medical negligence?

2. Whether § 502(a)(3) of ERISA, 29 USC § 1132(a)(3), permits plan beneficiaries to recover extracontractual damages for the wrongful death of their unborn child due to the medical negligence of a plan fiduciary?

PARTIES TO THE PROCEEDINGS

Florence Corcoran
Wayne Corcoran
United HealthCare Incorporated
Blue Cross and Blue Shield of Alabama, Inc.

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4 Health and Population Study Center, Battelle Human Affairs Research Centers, *Employee Welfare Benefits Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79* at 24 (1980) 8

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 965 F.2d 1321 (5th Cir. 1992), and is reproduced in the appendix at A-1 - A-38, The minute entry of the United States District Court for the Eastern District of Louisiana granting summary judgment to Respondent on preemption grounds, and that Court's minute entry denying Petitioners' motion for reconsideration pursuant to Federal Rule of Civil procedure 59 are unreported, and are reproduced in the appendix at A-48.

JURISDICTIONIONAL STATEMENT

The judgment of the Court of Appeals for the Fifth Circuit was entered on June 26, 1992. This Court has jurisdiction under 28 USC § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves §§ 502(a) and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 USC §§ 1132(a), 1144(a) (1990), and Louisiana Civil Code article 2315. These provisions are reproduced in the appendix at A-51 - A-54.

STATEMENT OF THE CASE

This case raises two related questions concerning the effect of ERISA on the quality of health care provided through employee benefits plans established pursuant to ERISA. The Petitioners, Wayne and Florence Corcoran, alleged that the medical negligence of United HealthCare, Inc. caused the wrongful death of their unborn son, Lloyd. The Court of Appeals for the Fifth Circuit concluded that, although there was evidence that "a serious mistake" had been made, ERISA afforded the Corcorans neither a state nor federal remedy for medical malpractice — in essence holding that when Congress passed ERISA in 1974, it intended to deprive beneficiaries of their state law causes of action for medical negligence, and all remedies for wrongful death occasioned by such negligence.

The Fifth Circuit's conclusion is clearly at odds with Congress' express legislative purpose of securing employee rights in their pension plans, 29 USC § 1001, and results from an overly broad construction and application of ERISA's preemption provision without adequate regard for the purpose of the statute as a whole and its other provisions.

1. In approximately February, 1989, petitioner, Florence Corcoran, became pregnant with what would have been her third child. Mrs. Corcoran was an employee of South Central Bell at the time, and was covered by a health plan funded by Bell and administered by Blue Cross and Blue Shield of Alabama, Inc. Several medical factors made Mrs. Corcoran's third pregnancy a complicated and difficult one. Dr. Jason Collins, her obstetrician, felt that the pregnancy was sufficiently complicated to require Mrs. Corcoran to have complete bed rest during the final months of the pregnancy.

This was not Mrs. Corcoran's first high risk pregnancy. Her daughter, Amanda, aged six months, was also the result of a high risk pregnancy. Dr. Collins was Mrs. Corcoran's treating obstetrician for that pregnancy, and was well acquainted with the medical problems posed by Mrs. Corcoran's condition.

As Mrs. Corcoran approached her delivery date, Dr. Collins ordered her hospitalized so her condition could be monitored around the clock. This was precisely the same course of action he had taken during her previous pregnancy, which resulted in the healthy birth — albeit by caesarean section — of Amanda Corcoran.

One component of the Blue Cross insurance plan was known as the Quality Care Program ("QCP"), which was operated by defendant, United HealthCare, Inc. United HealthCare, Inc. contracted with Blue Cross to provide this service, which was essentially a medical review or utilization review service. Mrs. Corcoran was a member of the Quality Care Program during the pregnancy at issue.

United HealthCare set forth the features of the Quality Care Program in a booklet. On page 1 of that booklet, United HealthCare made the following representations concerning the services provided to members of the program, such as Florence Corcoran:

WHAT QCP DOES

> Whenever your doctor recommends surgery or hospitalization for you or a covered dependent, QCP will provide an independent review of your condition (or your covered dependent's). The purpose of the review is to assess the need for the surgery or hospitalization and to determine the appropriate length of stay for a hospitalization,

> based on nationally accepted medical guidelines. As part of the review process, QCP will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments - or locations for treatment - that are equally effective, involve less risk, and are more cost effective.
>
> INDEPENDENT, PROFESSIONAL REVIEW
>
> United HealthCare, an independent professional medical review organization, has been engaged to provide services under QCP. United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care.

Similar representations are made at page 2 of the booklet, in response to the query "What does It Do?":

> Provides independent, professional review when hospitalization is recommended — **to assist you in making an enlightened decision regarding your treatment.**

(emphasis added). In the same section, the participant is informed that failure to follow the medical advice of United HealthCare could result in increased health risks.

Elsewhere in the booklet, United HealthCare informs participants that much of the care recommended by their own doctors is unnecessary. For example, at pages 5 and 6 of the booklet, in a section entitled, "Quality Care· The What and The Why", the following information is provided:

ONE-THIRD OF SURGERY MAY BE UNNECESSARY

Recent studies suggest about one-third of all surgery performed in the U.S. may be medically necessary. Why is there all this unnecessary surgery?

UNNECESSARY HOSPITAL STAYS

It used to be that the hospital was the only place for many kinds of treatments and tests. That's not the case any longer. Today, many kinds of treatments — even many surgeries — can be performed in a doctor's office or a free-standing clinic. The advantage? **You're in and out the same day and there's no hospital stay which can be dangerous and can cost as much as $300 per day just for room and board.**

Review by United HealthCare is not elective. At page 8 of the QCP booklet, United HealthCare plainly states that it must be called as a condition of every proposed hospitalization, so that United HealthCare could precertify the treatment to be received. Pursuant to these provisions, United HealthCare was notified when Dr. Collins ordered Mrs. Corcoran to be hospitalized for the remainder of her pregnancy.

Upon notification, United HealthCare made its own determination of Mrs. Corcoran's medical needs. It determined that hospitalization was not medically necessary, despite the fact that the same course of treatment had proved successful during Mrs. Corcoran's prior pregnancy, and despite the further fact that two medical doctors — Dr. Collins and independent medical examiner, Dr. Ward, hired by South Central Bell[1] — agreed that Mrs. Corcoran's

[1] When Dr. Collins first ordered bed rest for Mrs. Corcoran, she applied

medical condition was dangerous. Indeed, Dr. Ward explicitly stated that Dr. Collins' recommendation should be followed. Dr. Collins personally and specifically advised personnel of United HealthCare that, if Mrs. Corcoran were not hospitalized as he had ordered, both she and her baby could die. Nevertheless, United HealthCare made the medical judgment that 10 hours of home nursing care a day would be adequate treatment for Mrs. Corcoran's condition.

Consequently, Mrs. Corcoran was discharged from the hospital on October 12, 1989. On October 25, 1989, during a period of time when no home nurse was on duty, the Corcorans' unborn son went into distress and ultimately died. Dr. Collins believed that, had the fetus been monitored around the clock as he had ordered, he would have been able to intervene and save the child, as he had done the year before when the same thing happened to Amanda.

2. The Corcorans brought this wrongful death action alleging medical negligence in Louisiana state court. The Corcorans contended that United HealthCare, through the statements made in the QCP booklet, held itself out as a medical professional, and that its negligent medical judgment subjected it to tort liability for Lloyd's death under Louisiana tort law. The Corcorans distinguished United HealthCare's actions as a medical professional from those undertaken as an ERISA plan administrator. The suit was not premised on improper claims processing or coverage determination, but rather upon United HealthCare's

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Footnote 1 continued.

for temporary disability benefits, which Bell promptly denied. When Dr. Collins complained that no obstetrician was on the benefits review panel, Bell secretly sent her file to Dr. Ward for review. Even though Dr. Ward agreed with Dr. Collins, Bell did not pay disability benefits until Lloyd died.

negligence in failing to determine the appropriate medical care for Mrs. Corcoran. The Corcorans sought damages for the lost love and affection of their son, as well as medical expenses, lost wages and general damages for Mrs. Corcoran's depression triggered by Lloyd's wrongful death.

United Healthcare removed the suit to the United States District Court for the Eastern District of Louisiana, and pled ERISA preemption as a defense. United Healthcare then moved for summary judgment.

3. The district court granted summary judgment in favor of United Healthcare on preemption grounds. Without actually analyzing the nature and source of the Corcorans' claim, the district court held that "but for the ERISA plan, the defendants would have played no role in Mrs. Corcoran's pregnancy," and thus held the claim preempted because it "related to" an ERISA plan.

The Corcorans then moved for reconsideration on the grounds that the preempted remedies were available as "other appropriate equitable relief," pursuant to 29 USC § 1132 (a)(3), for violations by ERISA fiduciaries of their responsibilities under the plan. A contrary conclusion would leave the Corcorans without a remedy for the wrongful death of their son, a result directly at odds with ERISA's stated purpose of protecting employees and their families.

The district court denied the motion, holding that the only monetary relief recoverable under ERISA was "medical expenses covered by the plan"; that is, contractual damages. Further, the court appeared to conclude that United Healthcare had no substantive duty to make correct medical decisions, and thus could not be responsible for damages in any event. The Corcorans appealed to the Fifth Circuit.

4. The Court of Appeals affirmed in a lengthy and detailed opinion. Finding the facts to be undisputed, the Fifth Circuit agreed with the Corcorans' position that United HealthCare made medical decisions and gave medical advice concerning appropriate care for Mrs. Corcoran in the last month of her pregnancy. Further, the court recognized that the context in which such medical advice was given — a prospective utilization review — was calculated to induce reliance by the participant upon the advice. The court noted and discussed the coercive effect such a procedure produces, and is designed to produce. Finally, the court acknowledged evidence that a serious medical mistake resulted in the death of Lloyd Corcoran.

Nevertheless, the Fifth Circuit held that the Corcorans' medical malpractice claim against United HealthCare was preempted because it "related to" an ERISA plan. The court felt that United HealthCare's medical decision-making was too closely intertwined with its coverage determinations to avoid preemption. The court also determined that compensatory money damages were unavailable under 29 USC § 1132(a)(3). Although the court suggested that an award of money damages would be appropriate in certain cases as "make whole" relief, and would not conflict with the legislative purposes of ERISA, it concluded that the type of damages sought by the Corcorans was not recoverable. The court acknowledged that its result left the Corcorans without a remedy for the wrongful death of their son.

The Court of Appeal found its holding "troubling" for several reasons. First, it realized that the absence of a damage remedy for medical negligence eliminated an important check on substandard medical decisions. Second, it exacerbated the inherent tension between the beneficiary and the plan over entitlement to plan funds (although the

court also acknowledged that liability in this case would not compromise plan funds, since United HealthCare would be directly responsible), and further tilted the scales in favor of the plan. Finally, the court believed that the widespread institution of prospective utilization review programs, subsequent to ERISA's enactment and operating in a field where no liability rules applied to deter negligent conduct, undermined ERISA's purpose of protecting beneficiaries. The Corcorans now seek review of the court's decision.

REASONS FOR GRANTING THE WRIT

As the current presidential campaign reflects, health care and the current system for providing it are issues of national importance. Much of the health care received by Americans is provided through health plans established as part of a benefit plan governed by ERISA. Studies by the Department of Labor indicate that in the United States there are approximately 500,000 private pension plans, which alone cover over 50,000,000 individuals, as well as an estimated 1.6 million sponsors of private employee welfare benefit plans. See U.S. Dep't of Labor, Labor Management Services Admin., Pension and Welfare Benefits Programs, *Estimates of Participant and Financial Characteristics of Private Pension Plans* at 1 (1983); 4 Health and Population Study Center, Battelle Human Affairs Research Centers, *Employee Welfare Benefits Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-79* at 24 (1980). More recently, it has been estimated that 81% of all workers in medium and large firms were covered by at least one retirement plan in 1989. See U.S. Dep't. of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Firms, 1989* at 2 (1990).

The Court of Appeals held that there is no remedy

available for the consequences of negligent medical judgments made by those affiliated with ERISA plans. In other words, under ERISA liability rules are "generally inapplicable" to acts of medical malpractice. The Court of Appeals recognized that its holding would have a deleterious effect on the quality of health care provided under the auspices of ERISA plans, because liability rules are one deterrent to arbitrary medical decision-making. Note, *Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions*, 25 Ga.L.Rev. 861, 907-11 (1991) (arguing that without liability for negligence in utilization review decisions, third party payors have incentives to control costs but not to use reasonable care in the decision making process); *Mellas, Adopting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U.Colo.L.Rev. 287, 316 (1991) (liability will reduce possibility that poor medical decisions will be made in order to cut costs). When one recalls the vast number of Americans covered by benefit plans, many if not most with health plan components, it becomes evident that the issue presented in this case — whether state or federal law provides a remedy for medical negligence committed by an ERISA fiduciary — is one of pressing national significance.

There is a split in authority over whether ERISA preempts professional malpractice claims. The Fifth Circuit said yes in this case, but the Third Circuit and the Seventh Circuit have indicated otherwise. Several district courts have held that ERISA does not preempt medical negligence claims.

The Courts of Appeals are also divided over whether § 1132(a)(3) authorizes an award of money damages as "other appropriate equitable relief." The Sixth Circut held such relief was permitted where necessary to do complete justice, but numerous other circuits have disagreed. This

issue is ripe for resolution, but it only becomes pressing in this case if the Petitioners' tort claims are held preempted. Both issues present the critical question whether ERISA allows a remedy for wrongful death due to the medical negligence of an ERISA fiduciary, and its answer will substantively impact the quality of health care received in America today.

I. TO RESOLVE A CONFLICT IN THE CIRCUITS OVER WHETHER PROFESSIONAL MALPRACTICE ACTIONS SUCH AS THIS ONE ARE PREEMPTED BY 29 USC § 1144(a)

The Fifth Circuit characterized the Corcorans' claim as one for "malpractice," and expressly concluded that United HealthCare's actions with regard to Florence Corcoran constituted medical decision-making. In so holding, the Court of Appeals specifically rejected United HealthCare's position, maintained throughout this litigation, that it did nothing more than process the Corcorans' claim for health benefits, and that consequently the suit should be summarily dismissed under *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987), as one for improper claim processing. The Fifth Circuit further noted that Louisiana law did not foreclose a tort action for malpractice against a utilization review company such as United HealthCare that dispensed erroneous medical judgments.[2] However, the Court of Appeals held that any

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[2] Indeed, Louisiana law favors such a cause of action. Louisiana law already recognizes a cause of action under Louisiana Civil Code article 2315 for the wrongful death of an unborn fetus. *Danos v. St. Pierre*, 402 So.2d 633 (La. 1981). Moreover, Louisiana jurisprudence places heightened obligations upon those possessing medical skills. *Pitre v. Opelousas General Hospital*, 530 So.2d 1151, 1157 (La. 1988) (persons with medical expertise "owe a heavy moral obligation to use them carefully and to avoid foreseeable harm ..."). Inasmuch as United HealthCare made specific representations of medical expertise to

state law causes of action for malpractice arising from United HealthCare's negligent medical decisions were preempted by 29 USC § 1144(a).

The Third Circut reached the opposite conclusion with respect to professional malpractice actions generally in *Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse,* 879 F.2d 1146 (3rd Cir. 1989). The plaintiff in *Painters of Philadelphia* was an employee welfare fund who brought an action under ERISA against the fund's former auditor, the accounting firm of Price Waterhouse. The fund sought to hold Price Waterhouse liable for excessive fees charged in connection with audits performed for the fund. One of the fund's arguments was that, in the absence of an express cause of action for professional malpractice under ERISA, the court should find an implied right of action for professional malpractice under ERISA. The fund's implied right of action theory apparently was premised on its assumption that 29 USC § 1144(a) would preempt any state law malpractice action.

The Third Circuit refused to find an implied right of action for professional malpractice under ERISA. 879 F.2d at 1153. The court first found that an implied right of action was not consistent with ERISA's legislative scheme. 987 F.2d at 1152. Then the court noted that "state law has traditionally prescribed the standards of professional liability and in the absence of clear indicia in the act or legislative history ***we are reluctant to ascribe to Congress an intention to intrude in this area.***" *Id.* (emphasis added).

Footnote 2 continued.

Florence Corcoran, it follows as a matter of Louisiana law that its actions should be judged by applicable medical standards of care. See also *Green v. Walker,* 910 F.2d 291, 296 (5th Cir. 1990) (person "held out to the world as skilled in a medical profession" has duty of due care) (applying Louisiana law).

The court then addressed and rejected the fund's argument that ERISA preempted "state professional malpractice claims as they related to ERISA." 879 F.2d at 1153 n.7. Relying upon this Court's decision in *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 108 S.Ct. 2182 (1988), which acknowledged that torts committed by an ERISA plan were not preempted, 486 U.S. at 833, 108 S.Ct. at 2187, the Third Circuit stated:

> ... in the absence of an explicit corresponding provision in ERISA allowing a professional malpractice cause of action, ***Congress did not intend to preempt a whole panoply of state law in this area.*** Thus, we conclude that ERISA does not generally preempt state professional malpractice actions.

Painters of Philadelphia, 879 F.2d at 1153 n.7 (emphasis added). The court premised its conclusion upon the facts that 1) professional malpractice liability was a matter of traditional state regulations, and 2) there was no explicit provision in ERISA to permit such actions under its provision if state law were preempted.[3]

Numerous district courts have concluded that medical malpractice actions are not preempted by ERISA. In *Pickett v. Cigna Healthplan of Texas, Inc.*, 742 F.Supp. 946 (S.D. Tex. 1990), the court remanded a medical malpractice case brought against the administrator of an ERISA plan (Cigna) and three doctors, alleging no specific act of malpractice but rather claiming that a doctor rotation system devised by Cigna was an unreasonable medical

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[3] See also *Pappas v. Buck Consultants, Inc.*, 923 F.2d 531 (7th Cir. 1991), where the Seventh Circuit relied in part on *Painters of Philadelphia* to conclude state law malpractice actions are not preempted by ERISA.

procedure. The case had originally been brought in state court and was removed to federal court on the basis that it was actually an ERISA claim raising questions of plan administration. The district court remanded the case because it presented no question under ERISA but instead raised "a question of medical care not claims administration." 742 F.Supp. at 946. The court recognized that Cigna, although an ERISA plan manager, was being sued for medical negligence, and that the suit sought tort damages which were unavilable under ERISA, and not plan benefits. The court plainly held that medical malpractice actions were not preempted by ERISA.

In *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D. Pa. 1990), the court similarly concluded that a medical malpractice action brought by an ERISA plan beneficiary against her HMO, who was an ERISA plan fiduciary, was not preempted. The court concluded that the state law tort action did not "affect the scheme carefully devised by Congress in the ERISA statute," 733 F.Supp. at 988, even though the claim was made by an ERISA plan beneficiary against an ERISA entity for negligent medical decisions. The court determined that:

> The congressional purpose underlying the breadth of ERISA's preemption provision — to secure uniform federal laws regulating employee benefit plans — is not advanced by preemption of state common law claims which are not premised on the violation of duties imposed by ERISA.

Id., quoting *Albert Einstein Medical Center v. Action Manufacturing Company*, 697 F.Supp. 883, 885 (E.D. Pa. 1988).

This Court should grant a writ in this case to resolve

the conflict in the circuit courts over whether medical malpractice actions are preempted by ERISA, particularly in view of the impact the question has on the quality of health care received by Americans covered by ERISA plans.

II. THE FIFTH CIRCUIT'S DECISION CONFLICTS WITH 1) THIS COURT'S PRIOR DECISIONS CONSTRUING 29 USC § 1144(a), AND 2) THE LEGISLATIVE PURPOSE EMBODIED IN ERISA

A second reason for granting the writ in this case is that the Fifth Circuit's decision that ERISA preempts a traditional state law tort claim like medical malpractice conflicts with this Court's decision construing 29 USC § 1144 (a), and frustrates the legislative purpose in enacting ERISA. In *Mackey, supra*, 486 U.S. 825, 108 S.Ct. 2182 (1988), this Court considered whether ERISA § 514(a), 29 USC § 1144(a), preempted state garnishment laws as they applied to plan funds. In so doing, the Court identified a range of state law claims left undisturbed by ERISA, stating:

> ERISA plans may be sued in a second type of civil action, as well. These cases — lawsuits against ERISA plans for run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, **or even torts committed by an ERISA plan** — are relatively commonplace. Petitioners and the United States (appearing here as amicus curiae) concede that these suits, although **obviously affecting and involving ERISA plans and their trustees, are not pre-empted by ERISA § 514(a).**

486 U.S. at 833, 108 S.Ct. at 2187 (emphasis added).

The *Mackey* court, after noting that ERISA contained a "sue and be sued" provision, held that state garnishment law was not preempted because to hold otherwise would produce an absurd result: an ERISA plan could be sued but a money judgment against it could not be collected. The Fifth Circuit's decision, finding preemption of a run-of-the-mill tort claim for medical malpractice against an ERISA fiduciary, produces similarly absurd results. The Court of Appeals erred in failing to construe § 1144(a) in light of ERISA as a whole, notably § 1132(a)(3)(B), and the purposes for which it was enacted.

Although § 1144(a) may be "conspicuous for its breadth," *Ingersoll-Rand Co. v. McClendon*, 498 U.S. ____, ____, 111 S.Ct. 478, 482 (1990), this Court has never applied it to frustrate the purposes of Congress in enacting ERISA.[4] Whether or not a federal statute preempts state law depends upon "Congress' intent in enacting the federal statute at issue." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 738, 105 S.Ct. 2380, 2388 (1985); *Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 8, 107 S.Ct. 2211, 2216 (1987). Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefits plans." 29 USC § 1001; *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 90, 103 S.Ct. 2890, 2896 (1983).

The preemption analysis "must be guided by respect for the separate spheres of governmental authority preserved in our federalist system." *Aiessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522, 101 S.Ct. 1895, 1905 (1981). In this regard, the Court must presume that Con-

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[4] Or as one district judge succinctly stated, "the cases stressing the broad reach of ERISA preemption clause also stress that common sense should not be left at the courthouse door." *Schultz v. National Coalition of Hispanic M.H.H.S. Org.*, 678 F.supp. 936, 938 (D.D.C. 1988).

gress did not intend to preempt areas of traditional state regulation. *Metropolitan Life, supra*, 471 U.S. at 740, 105 S.Ct. at 2389.

The preemption provision must not be read in a vacuum. This Court has explained that "in expounding a statute, [it] must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *Pilot Life*, 481 U.S. at 51; 107 S.Ct. at 1555 (1987). Accordingly, § 1144(a) must be read in light of the statute as a whole — including the remedies available at § 1132(a)(3)(B), and those not available — in order for it to be applied in a manner consistent with Congress' intent to protect the rights and welfare of beneficiaries.

The Fifth Circuit concluded that ERISA provided no remedy for wrongful death due to medical negligence under § 1132(a)(3)(B). If correct, that conclusion strongly suggests that Congress did not intend to preempt state law medical malpractice claims. In *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 104 S.Ct. 615 (1984), this Court held that the Atomic Energy Act did not preempt state law punitive damage claims, even though Congress intended through the Act to establish nuclear regulation and safety as a solely federal concern. In holding state tort claims not preempted, the Court relied heavily on the absence of any federal remedy for persons injured by conduct governed by the Act. Justice White wrote, "[i]t is difficult to believe that Congress would, without comment, remove all means of judicial recourse for those injured by illegal conduct." *Silkwood*, 464 U.S. at 251, 104 S.Ct. at 623. See also *Cipollone v. Liggett Group, Inc.*, ____, U.S. ____, ____, 112 S.Ct. 2608, 2628, 112 (1991) (BLACKMUN, J., concurring in part and dissenting in part) ("The Court in the past has hesitated to find preemption where federal law provides no

comparable remedy").

The same difficulty described in *Silkwood* obtains in this case. It is difficult to believe that Congress, who sought to protect beneficiaries like the Corcorans through ERISA, intended to deprive them of all remedies for wrongful death due to medical negligence. There is no suggestion in the legislative history of ERISA that Congress intended to make medical malpractice one of the acceptable costs of securing workers' pension plan rights. Congress' failure to provide a remedy for medical negligence under ERISA reinforces the initial presumption that Congress did not intend to preempt traditional state control of the field of medicine.

Nor is this conclusion altered by the fact that ERISA contains a civil enforcement scheme. This Court has characterized the ERISA enforcement scheme as "comprehensive," and so it may be where an entitlement to plan benefits is concerned. But the Corcorans' claim lies beyond the pale of the ERISA enforcement scheme. The Corcorans do not seek plan benefits, but rather an award of money damages for wrongful death, previously available under state law prior to ERISA's enactment, and, accordingly to the Fifth Circuit, not recoverable under ERISA.[5] Moreover, the Atomic Energy Act at issue in *Silkwood, supra*, also contained a civil enforcement scheme, but this Court rejected the argument, advanced by the United States as amicus curiae, that state law tort claims were preempted because they conflicted with that scheme. The Court found no such conflict in *Silkwood*, and there is none

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[5] This Court in *Firestone Tire and Rubber Company v. Bruch*, 489 U.S. ___, 109 S.Ct. 948 (1989), cautioned against a construction of ERISA that would "afford less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." 109 S.Ct. at 956. The Fifth Circuit's decision does just that.

in this case.

An application of § 1144(a) in this case consistent with the legislative purpose of ERISA, the remedies authorized by § 1132(a)(3)(B), and the presumption against preemption of traditional state areas of control such as medical and tort law, results in the conclusion that Petitioners' claim for medical malpractice must not be preempted. Indeed, United HealthCare apparently contemplated the potential for malpractice suits against it for, as the Fifth Circuit noted at 965 F.2d 1338 n.20, its contract with Blue Cross provided that it would bear the cost of its negligence. Accordingly, the Petitioners' claim does not threaten any fund assets.

This case falls within the dicta in *Mackey* that state law claims like torts committed by an ERISA plan — here the tort of medical malpractice — are not preempted. To hold otherwise frustrates Congress' purpose of protecting worker's rights.

III. TO RESOLVE A SPLIT IN THE CIRCUITS OVER WHETHER EXTRACONTRACTUAL MONEY DAMAGES ARE RECOVERABLE UNDER 29 USC § 1332(a)(3)(B) AS "OTHER APPROPRIATE EQUITABLE RELIEF"

If the Fifth Circuit properly concluded that Petitioners' medical negligence claims were preempted, then this application squarely presents the question specifically reserved by this Court in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985): whether extracontractual money damages are available as "other appropriate equitable relief" under 29 USC § 1132(a)(3)(B).

The lower courts are divided over the question. The

Sixth Circuit held such damages were available in *Warren v. Society Nat. Bank*, 905 F.2d 975 (6th Cir. 1990), *cert. denied*, 111 S.Ct. 2256 (1991). Every other circuit which has considered the question determined that such extracontractual damages were available under ERISA. *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909, 109 S.Ct. 261, 102 L.Ed.2d 249 (1988); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir. 1992), *petition for cert. filed*, 60 U.S.L.W. (U.S. May 11, 1992) (no. 91-1835); *Novak v. Anderson Corp.*, 962 F.2d 757 (8th Cir. 1992); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986); *Bishop v. Osborn Transp., Inc.*, 838 F.2d 1173 (11th Cir.), *cert. denied*, 488 U.S. 832, 109 S.Ct. 90, 102 L.Ed.2d 66 (1988). The Fifth Circuit in this case did not decide the question because it concluded that, even if extracontractual damages were available, the type of tort damages sought by petitioners would nevertheless be barred.

1. In *Russell, supra*, this Court held that extracontractual damages were unavailable under 29 USC § 1109, which authorized suits by beneficiaries or plans to recover for losses suffered by the plan. The Court specifically reserved the question whether such relief would be available under § 1132 (a)(3)(B) for a fiduciary's breach of a duty owed to the beneficiary. *Id.*, 473 U.S. 139 n.5, 105 S.Ct. 3088 n.5. Four justices concurred in *Russell*, however, in an opinion by Justice Brennan, and indicated that the decision should not be applied beyond its narrow holding under § 1109. The concurrence explicitly stated that an extension of the Court's reasoning beyond § 1109 to support a conclusion, advanced by United HealthCare below, that extracontractual damages were nowhere authorized by ERISA would be "simply incompatible with the structure, legislative history, and purposes of ERISA." *Id.*, 473 U.S. at 152, 105 S.Ct. at 3095 (Brennan, J., concurring).

Justice Brennan especially emphasized throughout his concurring opinion Congress' intent to impose strict fiduciary obligations upon plan administrators. ERISA § 404(a), codified at 29 USC § 1104(a), provides in part that "a fiduciary shall discharge his duties with respect to a plan **solely in the interest of the participants and beneficiaries** and — (A) for the exclusive purpose of (i) providing benefits to participants and beneficiaries." The concurrence then analyzed the legislative history of ERISA, noting that "Congress intended federal courts to develop federal common law in fashioning the additional 'appropriate equitable rellief'," explicitly provided as a remedy under § 1132(a)(3). *Russell*, 473 U.S. 156, 105 S.Ct. 3097 (Brennan, J., concurring).[6] Justice Brennan concluded that extracontractual damages were available as "appropriate equitable relief" under 29 USC § 1132(a) in appropriate cases for violations of the fiduciary responsibilities set fort at § 1104(a).

In fashioning an appropriate remedy, Justice Brennan stated that courts should first look to trust law. *Russell*, 473 U.S. 157, 105 S.Ct. 3098. But he noted that to resort to trust law was not the only step, but merely the first in considering remedies. At footnote 17 of his opinion, Justice Brennan wrote:

> [17] The absence of such relief under traditional trust law is not necessarily dispositive, however, because "in enacting ERISA, Congress made **more** exacting the requirements of the common laws of trust relating to employee benefit funds."

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[6] Federal courts may look to preempted state law in developing federal common law for ERISA. *Singer v. Black & Decker Corp.*, 964 F.2d 1449, 1452-3 (4th Cir. 1992).

(citations omitted; original emphasis). Such damages are necessary to make beneficiaries whole, especially if all state law causes of action providing relief have been preempted.

The Sixth Circuit Court of Appeals in *Warren, supra,* relied extensively on Justice Brennan's *Russell* concurrence in expressly holding that § 1132(a)(3)(B) authorized extracontractual money damages as "other appropriate equitable relief." The *Warren* court first noted that the Supreme Court in *Russell* expressly left open the question of extracontractual damages under § 1132(a)(3), *Warren,* 905 F.2d at 981, then proceeded to rely upon Justice Brennan's concurring opinion in concluding they were available. *Id.,* 905 F.2d at 982 ("... a beneficiary is entitled to a remedy that will put him in the position he would have been in if the fiduciary had not committed a breach of trust, and ... such a remedy included monetary damages.").

The *Warren* court also relied on Justice Brennan's opinion in *Russell* in determining the type of remedy to allow. 905 F.2d at 982. In concluding that § 1132(a)(3) authorized a payment of money damages, Judge Lively wrote:

> ...equitable relief includes monetary damages where required to afford complete relief. It is the historic purposes of equity to secure complete justice, and courts may adjust their remedies so as to grant the necessary relief. Equitable relief may include monetary damages if necessary to do complete justice.
>
> The term "other appropriate equitable relief" implies a broad range of remedies. We adhere to the principle "endorsed repeatedly ... by the federal judiciary," that "when Congress uses broad generalized language in a remedial statute,

> and that language is not contravened by authoritative legislative history, a court should interpret the provision generously so as to effectuate the important congressional goals."

Id. (citations omitted). Inasmuch as Congress enacted ERISA as a remedial statute to protect and advance the interests of workers and plan beneficiaries, a narrow construction of ERISA impedes Congressional intent that courts develop a federal common law to shape relief. *See*: Note, "Participant and Beneficiary Remedies Under ERISA: Extracontractual and Punitive Damages After *Massachusetts Mutual Life Ins. Co. v. Russell*," 71 Cornell Law Review 1014, 1226 (1986). See also: *Russell, supra*, 473 U.S. 157, 103 S.Ct. 3098 (Congress intended the courts to undertake the process of delineating appropriate rights and remedies) (Brennan, J., concurring). A narrow construction of available remedies to ERISA beneficiaries under the Act would stand in ironic contrast to the broad application of the ERISA preemption clause, in that both have the effect of limiting the rights of the workers Congress sought to protect.

The scholarly literature also supports a finding that extracontractual damages should be available under § 1132(a)(3), in the wake of *Russell*. See, generally, Note, *supra*, 71 Cornell Law Review, 1014-1036, July 1986, which concluded that extracontractual but not punitive damages under § 1132(a)(3) were consistent with the purposes and language of ERISA, and not foreclosed by *Russell*. Accord: Gregory, "The Scope of ERISA Preemption of State Law: A Study of Effective Federalism," 48 U. Pitt. Law Rev. 427, 457 (1987). Gregory discusses the breadth of the preemption clause in the context of decisions limiting remedies under ERISA. His conclusion is that "if ERISA preempted all state law relating to employee benefit plans,

a dangerous vacuum would result." Gregory, *supra*, at 457 (emphasis added). If this court concludes that ERISA preempts plaintiffs' state law wrongful death claim, this "dangerous vacuum" can only be filled by finding that extracontractual damages are available in this case under 29 USC § 1132(a)(3).

This Court denied an application for certiorari filed by the ERISA plan, 111 S.Ct. 2256 (1991), and the Solicitor General filed a brief on behalf of the United States endorsing the Sixth Circuit's decision.

In *Ingersoll-Rand*, *supra*, 498 U.S. ____, 111 S.Ct. 478 (1990), this Court considered § 1132 (a)(3) and clearly suggested that extracontractual money damages were recoverable thereunder. Although the Court in *Ingersoll-Rand* did not discuss in detail what remedies are available as "other appropriate equitable relief" under § 1132 (a)(3), the Court, in reversing the judgment below, held that "there is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek 'pension benefits'." 111 S.Ct. at 486. The Court added: "it is clear that the relief requested" — which included a prayer for compensatory damages — "is well within the power of federal courts to provide." *Id.* Thus, the Court acknowledged that remedies beyond benefits were available under § 1132 (a), and could include compensatory damages.

The Courts of Appeals that have held extracontractual damages unavailable under § 1132 (a)(3) have essentially applied the rationale of *Russell*, developed for a section authorizing suits to recover for plan losses, to § 1132 (a)(3), which authorizes suits for losses suffered by the beneficiary. Justice Brennan's concurrence in *Russell* warned against this approach, noting that the sections serve different interests and warrant differing analyses.

Further, the holdings of these courts limit remedies under § 1132 (a)(3) to plan benefits and the traditional equitable remedies of injunction and declaratory relief (under the term "other appropriate equitable relief").

This construction of the statute is implausible. First, this Court in *Ingersoll-Rand* plainly stated that the language of § 1132(a) could not be limited to provide only for benefits as a remedy, intimating a broader range of remedies. Second, this construction of the "other appropriate equitable relief" language virtually reads it out of the statute. § 1132 (a)(1)(B) authorizes declaratory judgment actions and coercive relief by providing that any participant or beneficiary may bring suit "to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." In addition, § 1132(a)(3)(B) authorizes courts "to enjoin any act or practice which violates any provision of this [title] or the terms of the plan." Thus, the phrase "*other* appropriate equitable relief." if it is to have any significance, must authorize equitable remedies in addition to injunctions and declaratory judgments.

Finally, the statute's heavy reliance on principles of trust law, recognized by this Court in *Firestone*, 489 U.S. at ____, 109 S.Ct. at 954, forecloses a reading of § 1132(a)(3) which does not at least include "make whole" relief, for the reasons set forth by Justice Brennan in his *Russell* concurrence, and by *Warren*. Thus, the Sixth Circuit in *Warren* correctly determined that an award of money damages is available under 29 USC § 1132(a)(3).

2. The range of remedies available under § 1132(a)(3) as "other appropriate equitable relief" should include, in a wrongful death action due to a fiduciary's medical negligence, traditional tort compensatory damages. The

purpose of compensatory damages in a tort suit is the same as that of 'make whole" relief under equitable principles: to restore the victim as nearly as possible to the position he occupied prior to the wrongful act.

This Court signalled in *Ingersoll-Rand, supra*, that federal courts had broad power in ERISA suits to grant compensatory relief. The Court held plaintiff's claims, including a demand for compensatory damages such as mental anguish as well as punitive damages, preempted by ERISA. One justification given by Justice O'Connor for finding the state law claims preempted was that "it is clear that *the relief requested here* is well within the power of the federal courts to provide." *Id.*, 111 S.Ct. at 486 (emphasis added). Such a holding is critical to the efficacy of ERISA if § 1144(a) continues to receive indiscriminatively broad application, or beneficiaries such as the Corcorans will routinely find themselves without a remedy for breaches of fiduciary duty.

The Fifth Circuit concluded that, assuming the availability of extracontractual damages under ERISA, the Corcorans would still be unable to recover. The court reached this result by assuming that any such damages recoverable under ERISA would be limited to damages for breach of trust or contract. But as Justice Brennan explained in his concurring opinion in *Russell*, "Congress made *more exacting* the requirements of the common laws of trusts relating to employee benefit funds." *Id.*, 473 U.S. at 157 n.17, 105 S.Ct. at 3098 n.17 (emphasis added). Thus, the consideration of appropriate remedies is not limited, as the Fifth Circuit assumed, to remedies available under trusts or contract law, but must be determined with reference to "whether allowance or disallowance of particular relief would best effectuate the underlying purposes of ERISA." *Russell*, 473 U.S. at 158, 105 S.Ct. 3098.

Under this standard, a remedy for wrongful death due to breach of a fiduciary's duty is clearly necessary to the "enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and beneficiaries." *Id.* If ERISA is broad enough to include a utilization review company making medical decisions as a fiduciary, then it should also allow a remedy broad enough to correspond to potential damages caused by breach of the fiduciary's high duty. Otherwise the underlying purpose of ERISA will be thwarted, and a perversely anomalous situation will arise: those upon whom ERISA imposes high and exacting standards of care will be effectively relieved from any obligations to perform those duties responsibly. A remedy for a breach of duty is necessary to ERISA's purpose.

The terminology of § 1132(a)(3)(B) also reinforces this result. The statute speaks in terms of equitable relief. The foregoing demonstrates that this term is to be applied broadly, not literally. It has long been the law that "where legal rights have been invaded, and a federal statute provides for a general right to sue for such invasion, federal courts may use any available remedy to make good the wrong done." *Franklin v. Gwinnett County Public Schools*, ____, U.S. ____, 112 S.Ct. 1028, 1033 (1992). This is so, this Court continued in *Franklin*, because the existence of a statutory right implies the existence of all necessary and appropriate remedies. *Id.*, 112 S.Ct. at 1034.

Equitable relief encompasses the necessary money damages required to do complete justice. *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 418, 95 S.Ct. 2372 (1975); *Warren, supra.* Further, because it is the historic purpose of equity to secure complete justice, courts may adjust their remedies so as to grant necessary relief. *Walters v.*

Marathon Oil Co., 642 F.2d 1098, 1100 (7th Cir. 1982). Accordingly, where the wrong done results in the death of an unborn child, a court awarding equitable relief may fashion a money damage award as necessary to "make whole" the victim, to the extent money can. The purposes of ERISA to secure the welfare of covered employees require that an adequate remedy be provided for whatever breach of fiduciary duty might occur, and that remedy must include the type of damages sought herein.

CONCLUSION

The "troubling" result the Fifth Circuit felt compelled by ERISA to reach — that the Corcorans were afforded no remedy for the wrongful death of their unborn son — was required by neither the statute itself, nor Congress' purpose in enacting it. Instead, the Fifth Circuit's decision frustrates the intent of ERISA by depriving the beneficiaries Congress sought to protect of remedies they enjoyed prior to ERISA's passage. Further, the effect of the decision will be to reduce the quality of health care provided through plans governed by ERISA by removing all incentives for correct medical decision-making — an absurd result in light of express Congressional intent to secure the welfare of employees and their families through ERISA.

Petitioners' application for a writ of certiorari to the Court of Appeals for the Fifth Circuit should be granted.

Respectfully submitted,

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APPENDIX A

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

Filed
JUN 26 1992

No. 91-3322

FLORENCE B. CORCORAN
Wife of/and WAYNE D. CORCORAN,
Plaintiffs-Appellants,

v.

UNITED HEALTHCARE, INC.,
and BLUE CROSS and BLUE SHIELD
OF ALABAMA, INC.,
Defendants-Appellees.

Appeal from the United States District Court
for the Eastern District of Louisiana

Before THORNBERRY, KING, and DeMOSS, Circuit Judges.

KING, Circuit Judge:

This appeal requires us to decide whether ERISA pre-empts a state-law malpractice action brought by the beneficiary of an ERISA plan against a company that provides "utilization review" services to the plan. We also address the availability under ERISA of extracontractual damages. The district court granted the defendants' motion for summary judgment, holding that ERISA both pre-empted the plaintiffs' medical malpractice claim and

precluded them from recovering emotional distress damages. We affirm.

I. *BACKGROUND*

The basic facts are undisputed. Florence Corcoran, a long-time employee of South Central Bell Telephone Company (Bell), became pregnant in early 1989. In July, her obstetrician, Dr. Jason Collins, recommended that she have complete bed rest during the final months of her pregnancy. Mrs. Corcoran applied to Bell for temporary disability benefits for the remainder of her pregnancy, but the benefits were denied. This prompted Dr. Collins to write to Dr. Theodore J. Borgman, medical consultant for Bell, and explain that Mrs. Corcoran had several medical problems which placed her "in a category of high risk pregnancy." Bell again denied disability benefits. Unbeknownst to Mrs. Corcoran or Dr. Collins, Dr. Borgman solicited a second opinion on Mrs. Corcoran's condition from another obstetrician, Dr. Simon Ward. In a letter to Dr. Borgman, Dr. Ward indicated that he had reviewed Mrs. Corcoran's medical records and suggested that "the company would be at considerable risk denying her doctor's recommendation." As Mrs. Corcoran neared her delivery date, Dr. Collins ordered her hospitalized so that he could monitor the fetus around the clock.[1]

Mrs. Corcoran was a member of Bell's Medical Assistance Plan (MAP or "the Plan"). MAP is a self-funded welfare benefit plan which provides medical benefits to eligible Bell employees. It is administered by

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[1] This was the same course of action Dr. Collins had ordered during Mrs. Corcoran's 1988 pregnancy. In that pregnancy, Dr. Collins intervened and preformed a successful Caesarean section in the 36th week when the fetus went into distress.

defendant Blue Cross and Blue Shield of Alabama (Blue Cross) pursuant to an Administrative Services Agreement between Bell and Blue Cross. The parties agree that it is governed by ERISA.[2] Under a portion of the Plan known as the "Quality Care Program" (QCP), participants must obtain advance approval for overnight hospital admissions and certain medical procedures ("pre-certification"), and must obtain approval on a continuing basis once they are admitted to a hospital ("concurrent review"), or plan benefits to which they otherwise would be entitled are reduced.

QCP is administered by defendant United HealthCare (United) pursuant to an agreement with Bell. United performs a form of cost-containment services that has commonly become known as "utilization review." *See* Blum, *An Analysis of Legal Liability in Health Care Utilization Review and Case Management*, 26 Hous. L. Rev. 191, 192-93 (1989) (utilization review refers to "external evaluations that are based on established clinical criteria and are conducted by third-party payors, purchasers, or health care organizers to evaluate the appropriateness of an episode, or series or episodes, of medical care"). The Summary Plan Description (SPD) explains QCP as follows:

> The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and your covered dependents in securing quality medical care according to the provisions of the Plan while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in consultation with your doctor) to

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[2] Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829, 29 U.S.C. §§ 1001-1461.

> evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay is covered by the Plan.

Two paragraphs below, the SPD contains this statement: **When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor.** It goes on to explain that when a beneficiary does not contact United or follow its pre-certification decision, a "QCP Penalty" is applied. The penalty involves reduction of benefits by 20 percent for the remainder of the calendar year or until the annual out-of-pocket limit is reached. Moreover, the annual out-of-pocket limit is increased from $1,000 to $1,250 in covered expenses, not including any applicable deductible. According to the QCP Administrative Manual, the QCP penalty is automatically applied when a participant fails to contact United. However, if a participant complies with QCP by contacting United, but does not follow its decision, the penalty may be waived following an internal appeal if the medical facts show that the treatment chosen was appropriate.

A more complete description of QCP and the services provided by United is contained in a separate booklet. Under the heading "WHAT QCP DOES" the booklet explains:

> Whenever your doctor recommends surgery or hospitalization for you or a covered dependent, QCP will provide an independent review of your condition (or your covered dependent's). The purpose of the review is to assess the need for surgery or hospitalization and to determine the appropriate length of stay for a hospitalization,

> based on nationally accepted medical guidelines. As part of the review process, QCP will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments — or locations for treatment — that are equally effective, involve less risk, and are more cost effective.

The next paragraph is headed "INDEPENDENT, PROFESSIONAL REVIEW" and states:

> United Health Care, an independent professional medical review organization, has been engaged to provide services under QCP. United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care.

At several points in the booklet, the themes of "independent medical review" and "reduction of unnecessary risk and expense" are repeated. Under a section entitled "THE QUALITY CARE PROGRAM...AT A GLANCE" the booklet states the QCP "Provides independent, professional review when surgery or hospitalization is recommended — to assist you is making an enlightened decision regarding your treatment." QCP "provides improved quality of care by eliminating medically unnecessary treatment," but beneficiaries who fail to use it "may be exposed to unnecessary health risks. . . ." Elsewhere, in the course of pointing out that studies show one-third of all surgery may be unnecessary, the booklet explains that programs such as QCP "help reduce unnecessary and inappropriate care and eliminate their associated costs." Thus, "one important service of QCP will help you get a second opinion when your doctor recommends surgery."

The booklet goes on to describe the circumstances under which QCP must be utilized. When a Plan member's doctor recommends admission to the hospital,

> [i]ndependent medical professionals will review, with the patient's doctor, the medical findings and the proposed course of treatment, including the medically necessary length of confinement. The Quality Care Program may require additional tests or information (including second opinions), when determined necessary during consultation between QCP professionals and the attending physician.

When United certifies a hospital stay, it monitors the continuing necessity of the stay. It also determines, for certain medical procedures and surgeries, whether a second opinion is necessary, and authorizes, where appropriate, certain alternative forms of care. Beneficiaries are strongly encouraged to use QCP to avoid loss of benefits: " 'fully using' QCP means following the course of treatment that's recommended by QCP's medical professionals."

In accordance with the QCP portion of the plan, Dr. Collins sought pre-certification from United for Mrs. Corcoran's hospital stay. Despite Dr. Collins's recommendation, United determined that hospitalization was not necessary, and instead authorized 10 hours per day of home nursing care.[3] Mrs. Corcoran entered the hospital on October 3, 1989, but, because United had not pre-certified her stay, she returned home on October 12. On October 25, during a period of time when no nurse was on duty, the fetus went into distress and died.

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[3] The record does not reveal the name of the person or persons at United that made the decision concerning Mrs. Corcoran.

Mrs. Corcoran and her husband, Wayne, filed a wrongful death action in Louisiana state court alleging that their unborn child died as a result of various acts of negligence committed by Blue Cross and United. Both sought damages for the lost love, society and affection of their unborn child. In addition, Mrs. Corcoran sought damages for the aggravation of a pre-existing depressive condition and the loss of consortium caused by such aggravation, and Mr. Corcoran sought damages for loss of consortium. The defendants removed the action to federal court on grounds that it was pre-empted by ERISA[4] and that there was complete diversity among the parties.

Shortly thereafter, the defendants moved for summary judgment. They argued that the Corcorans' cause of action, properly characterized, sought damages for improper handling of a claim from two entities whose responsibilities were simply to administer benefits under an ERISA-governed plan. They contended that their relationship to Mrs. Corcoran came into existence solely as a result of an ERISA plan and was defined entirely by the plan. Thus, they urged the court to view the claims as "relating to" an ERISA plan, and therefore within the broad scope of state law claims pre-empted by the statute. In their opposition to the motion, the Corcorans argued that "[t]his case essentially boils down to one for malpractice against United HealthCare. . . ." They contended that under this court's analysis in *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987), their cause of action must be classified as a state law of

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[4] *See Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987) (because ERISA pre-emption is so comprehensive, pre-emption defense provides sufficient basis for removal to federal court notwithstanding "well-pleaded complaint" rule).

general application which involves an exercise of traditional state authority and affects principal ERISA entities in their individual capacities. This classification, they argued, together with the fact that pre-emption would contavene the purposes of ERISA by leaving the Corcorans without a remedy, leads to the conclusion that the action is premissible notwithstanding ERISA.

The district court, relying on the broad ERISA pre-emption principles developed by the Supreme Court and the Fifth Circuit, granted the motion. The court noted that ERISA pre-emption extends to state law claims " 'of general application,' including tort claims where ERISA ordinarily plays no role in the state law at issue." (citing *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58 (1987) and *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987)). The court found that the state law claim advanced by the Corcorans "relate[d] to" the employee benefit plan (citing the statutory pre-emption clause, ERISA § 514(a)), and therefore was pre-empted, because

> [b]ut for the ERISA plan, the defendants would have played no role in Mrs. Corcoran's pregnancy; the sole reason the defendants had anything to do with her pregnancy is because the terms of the ERISA plan directed Mrs. Corcoran to the defendants (or at least to United HealthCare) for approval of coverage of the medical care she initially sought.

The court held that, because the ERISA plan was the source of the relationship between the Corcorans and the defendants, the Corcorans' attempt to distinguish United's role in paying claims from its role as a source of professional medical advice was unconvincing.

The Corcorans filed a motion for reconsideration under Rule 59 of the Federal Rules of Civil Procedure. They did not ask the district court to reconsider its pre-emption ruling, but instead contended that language in the district court's opinion had implicitly recognized that they had a separate cause of action under ERISA's civil enforcement mechanism, § 502(a)(3).[5] They argued that the Supreme Court's decision in *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), did not foreclose the possibility that compensatory damages such as they sought constituted "other appropriate equitable relief" available under § 502(a)(3) for violations of ERISA or the terms of an ERISA plan. The district court denied the motion. Although the court recognized that there was authority to the contrary, it pointed out that "[t]he vast majority of federal appellate courts have . . . held that a beneficiary under an ERISA health plan may not recover under section 509(a(3) [sic] of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." (citations omitted). Moreover, the court pointed out, a prerequisite to recovery under § 502(a)(3) is a violation of the terms of ERISA itself. ERISA does not place upon the defendants a substantive responsibility in connection with the provision of medical advice which, if breached, would support a claim under § 502 (a)(3). The court entered final judgment in favor of Blue Cross and United, and this appeal followed.

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[5] The district court had stated that "[b]ecause the plaintiffs concede that the defendants have fully paid any and all medical expenses that Mrs. Corcoran actually incurred that were covered by the plan, the plaintiffs have no remaining claims under ERISA." In a footnote, the court indicated that Mrs. Corcoran could have (1) sued under ERISA, before entering the hospital, for a declaratory judgment that she was entitled to hospitalization benefits; or (2) gone into the hospital, incurred out-of-pocket expenses, and sued under ERISA for these expenses.

II. *STANDARD OF REVIEW*

Because this case is on appeal from the district court's grant of summary judgment, our review is plenary. *Dorsett v. Board of Trustees for State Colleges & Universities,* 940 F.2d, 121, 123 (5th Cir. 1991). We view the evidence in the light most favorable to the nonmoving party, *id.*, and must affirm if "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). As this case currently stands, the parties dispute not the relevant facts, but the legal conclusions that must be applied to those facts. As the Corcorans put it, "[t]he question on appeal is whether the plaintiffs are afforded any relief, under state law or ERISA, for damages caused by [the defendants' actions]."

III. *PRE-EMPTION OF THE STATE LAW CAUSE OF ACTION*

A. *The Nature of the Corcorans' State Law Claims*

The Corcorans' original petition in state court alleged that acts of negligence committed by Blue Cross and United caused the death of their unborn child. Specifically, they alleged that Blue Cross wrongfully denied appropriate medical care, failed adequately to oversee the medical decisions of United, and failed to provide United with Mrs. Corcoran's complete medical background. They alleged that United wrongfully denied the medical care recommended by Dr. Collins and wrongfully determined that home nursing care was adequate for her condition. It is evident that the Corcorans no longer pursue any theory of recovery against Blue Cross. Although they mention in their

appellate brief the fact that they asserted a claim against Blue Cross, they challenge only the district court's conclusion that ERISA pre-empts their state law cause of action against United.[6] We, therefore, analyze solely the question of pre-emption of the claims against United. *See Hulsey v. State of Texas,* 929 F.2d 168, 172 (5th Cir. 1991) (issues stated but not briefed need not be considered on appeal).

The claims against United arise from a relatively recent phenomenon in the health care delivery system — the prospective review by a third party of the necessity of medical care. Systems of prospective and concurrent review, rather than traditional retrospective review, were widely adopted throughout the 1980s as a method of containing the rapidly rising costs of health care. Blum, *supra,* at 192; Furrow, *Medical Malpractice and Cost Containment: Tightening the Screws,* 36 Case Western L. Rev. 985, 986-87 (1986). Under the traditional retrospective system (also commonly known as the fee-for-service system), the patient obtained medical treatment and the insurer reviewed the provider's claims for payment to determine whether they were covered under the plan. Denial of a claim meant that the cost of treatment was absorbed by an entity other than the one designed to spread the risk of medical costs — the insurer.

Congress's adoption in 1983 of a system under which hospitals are reimbursed for services provided to Medicare patients based upon average cost calculations for patients with particular diagnoses spurred private insurers to institute similar programs in which prospective decisions are made about the appropriate level of care. Although plans vary, the typical prospective review system requires some

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[6] They also do not mention Blue Cross when arguing that extracontractual damages are available under § 502(a)(3).

form of pre-admission certification by a third party (e.g., the HMO if an HMO-associated doctor provides care; an outside organization such as United if an independent physician provides care) before a hospital stay. Concurrent review involves the monitoring of a hospital stay to determine its continuing appropriateness. *See generally,* Blum, *supra,* at 192-93; Tiano, *The Legal Implications of HMO Cost Containment Measures,* 14 Seton Hall Legis. J. 79, 80 (1990). As the SPD makes clear, United performs this sort of prospective and concurrent review (generically, "utilization review") in connection with, *inter alia,* the hospitalization of Bell employees.

The Corcorans based their action against United on Article 2315 of the Louisiana Civil Code, which provides that "[e]very act whatever of man that causes damage to another obliges him by whose fault it happened to repair it." Article 2315 provides parents with a cause of action for the wrongful death of their unborn children, *Danos v. St. Pierre,* 402 So. 2d 633, 637-38 (La. 1981), and also places liability on health care providers when they fail to live up to the applicable standard of care. *Chivleatto v. Divinity,* 379 So. 2d 784, 786 (La. App. 4th Dist. 1979). Whether Article 2315 permits a negligence suit against a third party provider of utilization review services, however, has yet to be decided by the Louisiana courts. The potential for imposing liability on these entities is only beginning to be explored, with only one state explicitly permitting a suit based on a utilization review company's allegedly negligent decision about medical care to go forward. *Wilson v. Blue Cross of So. California,* 22 Cal. App. 3d 660, 271 Cal. Rptr. 876, 883 (1990) (reversing summary judgment for utilization review company which determined that further hospitalization was not necessary; ERISA not

implicated);[7] *see also Wickline v. State of California*, 192 Cal. App. 3d 1630, 239 Cal. Rptr. 810, 819 (1986) (stating, in dicta, that negligent implementation of cost containment mechanisms such as utilization review can lead to liability; ERISA not implicated), *cert. granted*, 727 P.2d 753, 231 Cal. Rptr. 560, *review dismissed, cause remanded*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).[8]

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[7] The case went to trial, but the plaintiff settled with Western Medical, the provider of utilization review services. *See* Milt Freudenheim, *When Treatment and Costs Collide*, N.Y. Times, Apr. 28, 1992, at C2 col. 1.

[8] Numerous commentators have weighed in on the propriety of liability for utilization review decisions. *See e.g.*, Macaulay, *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 19 Suffolk U.L. Rev. 91, 106-107 (1986) (arguing for higher standard of negligence in "*Wickline suits*"); Morreim, *Cost Containment and the Standard of Medical Care*, 75 Calif. L. Rev. 1719, 1749-50 (1987) (arguing that liability should be limited because patient's physician makes the ultimate decision about treatment); Note, *Paying the Piper: Third Party Payor Liability for Medical Treatment Decisions*, 25 Ga. L. Rev. 861, 907-911 (1991) (by David Griner) (arguing that without liability for negligence in utilization review decisions, third party payors have incentives to control costs but not to use reasonable care in the decisionmaking process); Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. Colo. L. Rev. 287, 316 (1991) (liability will reduce possibility that poor medical decisions will be made in order to cut costs).

Even if courts put their imprimatur on negligence actions against utilization review organizations, plaintiffs would face difficulties in proving that the organization's decision was a significant cause of an injury. *See Wickline*, 239 Cal. Rptr. at 819 (decision of doctor to discharge patient after Medi-Cal (state utilization review body) would not authorize additional hospital stay, not decision of Medi-Cal on appropriate length of stay, is act upon which liability should be premised); Note, *supra*, 25 Ga. L. Rev. at 902-05 (discussing problem of proving that utilization review organization's decision is proximate cause of injury); *but see Wilson*, 271 Ca. Rptr. at 883 (finding that plaintiffs had adduced enough evidence as to causal effect of utilization review company's decision on decedent's suicide to avoid summary judgment).

In the absence of clear Louisiana authority for their lawsuit, the Corcorans rely on *Green v. Walker*, 910 F.2d 291 (5th Cir. 1990). We held in *Green* that Article 2315 imposes a duty of due care upon physicians hired by employers to conduct employment-related exams on employees. *Id.* at 296. The cause of action recognized in *Green*, however, is not analogous to the cause of action brought against United because *Green* involved an actual physical examination by a doctor hired by an employer, not the detached decision of a utilization review company. Despite the lack of clear Louisiana authority supporting the Corcorans' theory of recovery against United, we can resolve the pre-emption question presented in this appeal. The law in this area is only beginning to develop, and it does not appear to us that Louisiana law clearly forecloses the possibility of recovery against United. Thus, assuming that on these facts the Corcorans might be capable of stating a cause of action for malpractice,[9] our task now is to determine whether such a cause of action is pre-empted by ERISA.

B. *Principles of ERISA Pre-emption*

The central inquiry in determining whether a federal statute pre-empts state law is the intent of Congress. *FMC Corp. v. Holiday*, 111 S. Ct. 403, 407 (1990); *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985). In performing this analysis we begin with any statutory language that expresses an intent to pre-empt, but we look also to the purpose and structure of the statute as a whole. *FMC Corp.*, 111 S. Ct. at 407; *Ingersoll-Rand Co. v. McClendon*, 111 S. Ct. 478, 482 (1990).

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[9] If the Corcorans could sue United on a negligence theory, it would appear that they could recover damages incurred in connection with the death of their unborn child. *Danos*, 402 So. 2d at 637.

ERISA contains an explicit pre-emption clause, which provides, in relevant part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a). . . .

ERISA § 514(a).[10] It is by now well-established that the "deliberately expansive" language of this clause, *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 42, 46 (1987), is a signal that it is to be construed extremely broadly. *See FMC Corp.*, 111 S. Ct. at 407 ("[t]he pre-emption clause is conspicuous for its breadth"); *Ingersoll-Rand*, 111 S. Ct. at 482.[11] The key words "relate to" are used in such a way as

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[10] Statutory, decisional and all other forms of state law are included within the scope of the preemption clause. ERISA § 514(c)(1) ("The term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State"). Section 514(b)(2)(A) exempts certain state laws from pre-emption, but none of these exceptions is applicable here.

[11] The legislative history indicates that Congress intended the preemption provision to be applied expansively. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the Court explained:

> The bill that became ERISA originally contained a limited preemption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R. Conf. Rep. No. 93-1280, p. 383 (1974); S. Conf. Rep. No. 93-1090, p. 383 (1974).

463 U.S. at 98. Senator Williams, one of ERISA's sponsors, remarked:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal

to expand pre-emption beyond state laws that relate to the specific subjects covered by ERISA, such as reporting, disclosure and fiduciary obligations. *Id.* at 482. Thus, state laws "relate[ ] to" employee benefit plans in a much broader sense — whenever they have "a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983). This sweeping pre-emption of state law is consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans. *See Ingersoll-Rand*, 111 S. Ct. at 482; *Pilot Life*, 481 U.S. at 45-46.

The most obvious class of pre-empted state laws are those that are specifically designed to affect ERISA-governed employee benefit plans. *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829-30 (1988) (statute explicitly barring garnishment of ERISA plan funds is pre-empted); *Ingersoll-Rand*, 111 S. Ct. at 483 (cause of action allowing recovery from employer when discharge is premised upon attempt to avoid contributing to pension plan is pre-empted). But a law is not saved from pre-emption merely because it does not target employee benefit plans. Indeed, much pre-emption litigation involves laws of general application which, when applied in particular settings, can be said to have a connection with or a reference to an ERISA plan. *See Pilot Life*, 481 U.S. at 47-48 (common law tort and contract causes of action seek-

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(footnote 11 continued)

> regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 Cong. Rec. 29933 (1974). *See also Pilot Life*, 481 U.S. at 46.

ing damages for improper processing of a claim for benefits under a disability plan are pre-empted); *Shaw*, 463 U.S. at 95-100 (statute interpreted by state court as prohibiting plans from discriminating on the basis of pregnancy is pre-empted); *Christopher v. Mobil Oil Corp.*, 950 F.2d 1209, 1218 (5th Cir. 1992) (common law fraud and negligent misrepresentation claims that allege reliance on agreements or representations about the coverage of a plan are pre-empted), *petition for cert. filed* 60 U.S.L.W. 3829 (U.S. May 26, 1992) (No. 91-1881); *Lee v. E.I. DuPont de Nemours & Co.*, 894 F.2d 755, 758 (5th Cir. 1990) (same). On the other hand, the Court has recognized that not every conceivable cause of action that may be brought against an ERISA-covered plan is pre-empted. "Some state actions may affect employee benefit plans in too tenuous, remote or peripheral a manner to warrant a finding that the law 'relates to' the plan." *Shaw*, 463 U.S. at 100 n.21. Thus, "run-of-the-mill state-law claims such as unpaid rent, failure to pay creditors, or even torts committed by an ERISA plan" are not pre-empted, *Mackey*, 486 U.S. at 833 (discussing these types of claims in dicta).

C. *Pre-emption of the Corcorans' Claims*

Initially, we observe that the common law causes of action advanced by the Corcorans are not that species of law "specifically designed" to affect ERISA plans, for the liability rules they seek to invoke neither make explicit reference to nor are premised on the existence of an ERISA plan. *Compare Ingersoll-Rand*, 111 S. Ct. at 483. Rather, applied in this case against a defendant that provides benefit-related services to an ERISA plan, the generally applicable negligence-based causes of action may have an effect on an ERISA-governed plan. In our view, the pre-emption question devolves into an assessment of the significance of these effects.

1. United's position — it makes benefit determinations, not medical decisions

United's argument in favor of pre-emption is grounded in the notion that the decision it made concerning Mrs. Corcoran was not primarily a medical decision, but instead was a decision made in its capacity as a plan fiduciary about what benefits were authorized under the Plan. All it did, it argues, was determine whether Mrs. Corcoran qualified for the benefits provided by the plan by applying previously established eligibility criteria. The argument's coup de grace is that under well-established precedent,[12] participants may not sue in tort to redress injuries flowing from decisions about what benefits are to be paid under a plan. One commentator has endorsed this view of lawsuits against providers of utilization review services, arguing that, because medical services are the "benefits" provided by a utilization review company, complaints about the quality of medical services (i.e., lawsuits for negligence) "can therefore be characterized as claims founded upon a constructive denial of plan benefits." Chittenden, *Malpractice Liability and Managed Health Care: History & Prognosis*, 26 Tort & Ins. Law J. 451, 489 (1991).

In support of its argument, United points to its explanatory booklet and its language stating that the company advises the patient's doctor "what the medical plan will pay for, based on a review of [the patient's] clinical information and nationally accepted medical guidelines for the treatment of [the patient's] condition." It also relies on statements to the effect that the ultimate medical decisions are up to the beneficiary's doctor. It acknowledges at various points that its decision about what benefits would be paid was based on a consideration of medical informa-

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[12] *Pilot Life*, 481 U.S. at 47-48.

tion, but the thrust of the argument is that it was simply performing commonplace administrative duties akin to claims handling.

Because it was merely performing claims handling functions when it rejected Dr. Collins's request to approve Mrs. Corcoran's hospitalization, United contends, the principles of *Pilot Life* and its progeny squarely forecloses this lawsuit. In *Pilot Life,* a beneficiary sought damages under various state-law tort and contract theories from the insurance company that determined eligibility for the employer's long term disability benefit plan. The company had paid benefits for two years, but there followed a period during which the company terminated and reinstated the beneficiary several times. 481 U.S. at 43. The Court made clear, however, that ERISA pre-empts state-law tort and contract actions in which a beneficiary seeks to recover damages for improper processing of a claim for benefits. *Id.* at 48-49. United suggests that its actions here were analogous to those of the insurance company in *Pilot Life,* and therefore urges us to apply that decision.

2. The Corcorans' position — United makes medical decisions, not benefit determinations

The Corcorans assert that *Pilot Life* and its progeny are inapposite because they are not advancing a claim for improper processing of benefits. Rather, they say, they seek to recover solely for United's erroneous medical decision that Mrs. Corcoran did not require hospitalization during the last month of her pregnancy. This argument, of course, depends on viewing United's action in this case as a medical decision, and not merely an administrative determination about benefit entitlements. Accordingly, the Corcorans, pointing to the statements United makes in the QCP booklet concerning its medical expertise, contend that

United exercised medical judgment which is outside the purview of ERISA pre-emption.

The Corcorans suggest that a medical negligence claim is permitted under the analytical framework we have developed for assessing pre-emption claims. Relying on *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987), they contend that we should not find the state law under which they proceed pre-empted because it (1) involves the exercise of traditional state authority and (2) is a law of general application which, although it affects relations between principal ERISA entities in this case, is not designed to affect the ERISA relationship.[13]

3. Our view — United makes medical decisions incident to benefit determinations

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[13] Amicus curiae Louisiana Trial Lawyers Association (LTLA) argues that United is not an ERISA fiduciary, and that therefore the tort claims against it cannot be pre-empted. The parties, however, agree that United is a fiduciary, and we have no reason to dispute this. United's contract with Bell would appear to give it "discretionary authority or discretionary control respecting management of [the] plan" or "authority or control respecting management or disposition of its assets. . . [,]" thus satisfying the statutory definition of a fiduciary. 29 U.S.C. § 1002(21)(A)(i). In any event, all courts of appeals to have considered the issue have held that ERISA pre-emption may apply regardless of whether the defendant is a plan fiduciary. *Consolidated Beef Indus., Inc. v. New York Life Ins. Co.*, 949 F.2d 960, 964 (8th Cir. 1991); *Gibson v. Prudential Ins. Co.*, 915 F.2d 414, 417-18 (9th Cir. 1990); *Howard v. Parisian, Inc.*, 807 F.2d 1560, 1564 (11th Cir. 1987). Despite the suggestion in *Howard* that this circuit so held in *Light v. Blue Cross and Blue Shield of Alabama*, 790 F.2d 1247 (5th Cir. 1986), there is no indication that the defendant in *Light* was not a fiduciary, and even if it was not, no part of the opinion considers the precise question whether ERISA pre-empts suits against nonfiduciaries.

We cannot fully agree with either United or the Corcorans. Ultimately, we conclude that United makes medical decisions — indeed, United gives medical advice — but it does so in the context of making a determination about the availability of benefits under the plan. Accordingly, we hold that the Louisiana tort action asserted by the Corcorans for the wrongful death of their child allegedly resulting from United's erroneous medical decision is preempted by ERISA.

Turning first to the question of the characterization of United's actions, we note that the QCP booklet and the SPD lend substantial support to the Corcorans' argument that United makes medical decisions. United's own booklet tells beneficiaries that it "assess[es] the need for surgery or hospitalization and . . . determine[s] the appropriate length of stay for a hospitalization, based on nationally accepted medical guidelines." United "will discuss with your doctor the appropriateness of the treatments recommended and the availability of alternative types of treatments." Further, "United's staff includes doctors, nurses, and other medical professionals knowledgeable about the health care delivery system. Together with your doctor, they work to assure that you and your covered family members receive the most appropriate medical care." According to the SPD, United will "provid[e] you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate."

United makes much of the disclaimer that decisions about medical care are up to the beneficiary and his or her doctor. While that may be so, and while the disclaimer may support the conclusion that the relationship between United and the beneficiary is not that of doctor-patient, it does not mean that United does not make medical decisions

or dispense medical advice. *See Wickline*, 239 Cal. Rptr. at 819 (declining to hold Medi-Cal liable but recognizing that it made a medical judgment); Macaulay, *Health Care Cost Containment and Medical Malpractice: On a Collision Course*, 19 Suffolk U.L. Rev. 91, 106-107 (1986) ("As illustrated in [*Wickline*], an adverse prospective determination on the 'necessity' of medical treatment may involve complex medical judgment.") (footnote omitted). In response, United argues that any such medical determination or advice is made or given in the context of administering the benefits available under the Bell plan. Supporting United's position is the contract between United and Bell, which provides that "[United] shall contract the Participant's physician and based upon the medical evidence and normative data determine whether the Participant should be eligible to receive full plan benefits for the recommended hospitalization and the duration of benefits."

United argues that the decision it makes in this, the prospective context, is no different than the decision an insurer makes in the traditional retrospective context. The question in each case is "what the medical plan will pay for, based on a review of [the beneficiary's] clinical information and nationally accepted medical guidelines for the treatment of [the beneficiary's] condition." *See* QCP Booklet at 4. A prospective decision is, however, different in its impact on the beneficiary than a retrospective decision. In both systems, the beneficiary theoretically knows in advance what treatments the plan will pay for because coverage is spelled out in the plan documents. But in the retrospective system, a beneficiary who embarks on the course of treatment recommended by his or her physician has only a potential risk of disallowance of all or a part of the cost of that treatment, and then only after treatment has been rendered. In contrast, in a prospective system a beneficiary may be squarely presented in advance of treat-

ment with a statement that the insurer will not pay for the proposed course of treatment recommended by his or her doctor and the beneficiary has the potential of recovering the cost of that treatment only if he or she can prevail in a challenge to the insurer's decision. A beneficiary in the latter system would likely be far less inclined to undertake the course of treatment that the insurer has at least preliminarily rejected.

By its very nature, a system of prospective decisionmaking influences the beneficiary's choice among treatment options to a far greater degree than does the theoretical risk of disallowance of a claim facing a beneficiary in a retrospective system. Indeed, the perception among insurers that prospective determinations result in lower health care costs is premised on the likelihood that a beneficiary faced with the knowledge of specificially what the plan will and will not pay for will choose the treatment option recommended by the plan in order to avoid risking total or partial disallowance of benefits. When United makes a decision pursuant QCP, it is making a medical recommendation which — because of the financial ramifications — is more likely to be followed.[14]

Although we disagree with United's position that no

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[14] It is the medical decisionmaking aspect of the utilization review process that has spawned the literature assessing the application of malpractice and other negligence-based doctrines to hold these entities liable for patient injuries. *See* Blum, *supra*, at 199 ("The overriding incentive for [utilization review] may be cost containment, but the process itself is triggered by a medical evaluation of a particular case, an evaluation that requires a clinical judgment.") (footnote omitted); Tiano, *supra*, at 80 ("The patient faces conflicting judgments by two medical professionals: the treating physician and the utilization review consultant"); Chittenden, *supra*, at 476 ("negligent implementation of cost-control mechanisms may affect the medical judgment of the physician or other provider resulting in physical injury to the patient").

part of its actions involves medical decisions, we cannot agree with the Corcorans that no part of United's actions involves benefit determinations. In our view, United makes medical decisions as part and parcel of its mandate to decide what benefits are available under the Bell plan. As the QCP Booklet concisely puts it, United decides "what the medical plan will pay for." When United's actions are viewed from this perspective, it becomes apparent that the Corcorans are attempting to recover for a tort allegedly committed in the course of handling a benefit determination. The nature of the benefit determination is different than the type of decision that was at issue in *Pilot Life*, but it is a benefit determination nonetheless. The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

Moreover, allowing the Corcorans' suit to go forward would contravene Congress's goals of "ensur[ing] that plans and plan sponsors would be subject to a uniform body of benefit law" and "minimiz[ing] the administrative and financial burdens of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand Co.*, 111 S. Ct. at 484; *see also Fort Halifax Packing*, 482 U.S. at 9-10. Thus, statutes that subject plans to inconsistent regulatory schemes in different states, thereby increasing inefficiency and potentially causing the plan to respond by reducing benefit levels, are consistently held pre-empted. *See Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981) (striking down law which prohibited plans from offsetting benefits by amount of worker compensation payments); *Shaw*, 463 U.S. at 105 n.25 (striking down law which compensation payments); *Shaw*, 463 U.S. at 105 n.25 (striking down law which prohibited plans from discriminating on basis of pregnancy); *FMC Corp.*, 111 S. Ct. at 408 (striking

down law which eliminated plans' right of subrogation from claimant's tort recovery). But in *Ingersoll-Rand*, the Court, in holding pre-empted the Texas common law of wrongful discharge when applied against an employer who allegedly discharged an employee to avoid contributing to the employee's pension plan, made clear that a state common law cause of action is equally capable of leading to the kind of patchwork scheme of regulation Congress sought to avoid:

> It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction. Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

111 S. Ct. at 484. Similarly, although imposing liability on United might have the salutary effect of deterring poor quality medical decisions,[15] there is a significant risk that state liability rules would be applied differently to the conduct of utilization review companies in different states. The cost of complying with varying substantive standards would increase the cost of providing utilization review services, thereby increasing the cost of health benefit plans of including cost containment features such as the Quality Care Program (or causing them to eliminate this sort of cost containment program altogether) and ultimately decreasing the pool of plan funds available to reimburse

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[15] *See* Comment, *A Cost Containment Malpractice Defense: Implications for the Standard of Care and for Indigent Patients*, 26 Hous. L. Rev. 1007, 1021 (1989) (by Leslie C. Giordani).

participants. *See* Macaulay, *supra*, at 105.[16]

It may be true, as the Corcorans asert, that Louisiana tort law places duties on persons who make medical judgments within the state, and the Louisiana courts may one day recognize that this duty extends to the medical decisions make by utilization review companies. But it is equally true that Congress may pre-empt state-law causes of action which seek to enforce various duties when it determines that such actions would interfere with a carefully constructed scheme of federal regulation. *See Pilot Life*, 481 U.S. at 48. The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the pre-emption clause leaves a gap in remedies within a statute

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[16] We find *Independence HMO, Inc. v. Smith*, 733 F. Supp. 983 (E.D. Pa. 1990), cited by the Corcorans, distinguishable on its facts. In *Smith*, the district court did not find pre-empted a state court malpractice action brought against an HMO by one of its members. The plaintiff sought to hold the HMO liable, under a state-law agency theory, for the alleged negligence of a surgeon associated with the HMO. The case appears to support the Corcorans because the plaintiff was attempting to hold an ERISA entity liable for medical decisions. However, the medical decisions at issue do not appear to have been made in connection with a cost containment feature of the plan or any other aspect of the plan which implicated the management of plan assets, but were instead made by a doctor in the course of treatment.

We also find *Eurine v. Wyatt Cafeterias*, No. 3-91-0408-H (N.D. Tex. Aug. 21, 1991), cited in the Corcorans' reply brief, irrelevant to this case. In *Eurine*, an employee of Wyatt Cafeterias sued after she slipped and fell at work. Wyatt had opted out of Texas's workers' compensation scheme, but provided benefits for injured employees pursuant to an ERISA plan. The court held that a tort suit against the employer for its negligence in failing to maintain the floor in a safe condition had nothing to do with the ERISA relationship between the parties, but instead arose from their distinct employer-employee relationship.

intended to protect participants in employee benefit plans, *see Shaw,* 463 U.S. at 90; *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 113 (1989), the lack of an ERISA remedy does not affect a pre-emption analysis. *Memorial Hosp.,* 904 F.2d at 248 & n.16; *Lee,* 894 F.2d at 757. Congress perhaps could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.

We are not persuaded that *Sommers Drug,* on which the Corcorans rely heavily, commands a different outcome. In *Sommers Drug,* we observed that courts are less likely to find pre-emption when the state law involves an exercise of traditional state authority than when the law affects an area not traditionally regulated by the states. *Id.* at 1467. The Corcorans contend that they easily pass this hurdle, as tort law traditionally has been reserved to the states, but this victory only puts them back at the starting line again. We went on to say in *Sommers Drug* that we were "not convinced" that the traditional or nontraditional nature of the state law properly bears upon the initial question whether it is pre-empted by § 514(a), because the distinction had no support in the statutory language. *Id.* at 1468. We continue to adhere to this view. As cases such as *Ingersoll-Rand and Christopher* illustrate, the fact that states traditionally

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(footnote 16 continued)

Finally, to the extent that two other decisions cited by the Corcorans, *Kohn v. Delaware Valley HMO, Inc.,* No. 91-2745 (E.D. Pa. Dec. 20, 1991 and Feb. 5, 1992), and *Cooney v. South Central Bell Tel. Co.,* No. 91-3870 (E.D. La. March 5, 1992), conflict with our holding, we decline to follow them.

have regulated in a particular area has functioned as no impediment to ERISA pre-emption. *See Ingersoll-Rand*, 111 S. Ct. at 483 (wrongful discharge action pre-empted); *Christopher*, 950 F. 2d at 1218 (fraud action pre-empted). ERISA's pre-emption section itself contains an explicit exemption for state laws that regulate in at least one area of traditional state function — insurance. ERISA § 514(b)(2)(A). There is no reason to believe that Congress intended implicitly to exempt a whole range of state laws when it showed itself perfectly capable of carving out specific exemptions.

The second factor identified in *Sommers Drug* as bearing on pre-emption — whether the state law affects relations among principal ERISA entities — continues to be relevant in this circuit, *see Memorial Hospital Systems v. Northbrook Life Insurance Co.*, 904 F.2d 236, 245, 248-50 (5th Cir. 1990), but it does not help the Corcorans. In the case before us, of course, the cause of action affects relations between principal ERISA entities. Nevertheless, the Corcorans argue, *Sommers Drug* holds that the claim will not be pre-empted where the state law is one of general application and it does not affect relations among the principal ERISA entities "as such," but in their capacities as entities in another kind of relationship. They analogize to *Sommers Drug*, where we held that a pension plan, acting in its "non-ERISA" capacity as a shareholder in a company, could invoke the state common law of corporate fiduciary duty against an officer and director of the company and a plan fiduciary to redress an alleged breach of fiduciary duty. 793 F.2d at 1468-70. The short answer to this argument is that the cause of action in this case is not between parties acting in the kind of non-ERISA context we found in *Sommers Drug*. Although the claims in *Sommers Drug* nominally affected relations between ERISA entities, the lawsuit had nothing to do with the plan. Here,

however, the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan. *Sommers Drug* does not mitigate the pre-emptive force of ERISA § 514(a).

IV. *EXTRACONTRACTUAL DAMAGES*

The Corcorans argue in the alternative that the damages they seek are available as "other appropriate equitable relief" under ERISA § 502(a)(3). That section provides:

> (a) A civil action may be brought —
>
> . . .
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin, any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;
>
> . . .

Although the Corcorans did not assert a cause of action under § 502(a)(3) in their original state court complaint, they asked the district court in their motion for reconsideration to award damages pursuant to this section. The defendants agreed at oral argument that the issue was properly raised and preserved for appeal, and we proceed to consider it.

Section 502(a)(3) provides for relief apart from an award of benefits due under the terms of a plan. When a beneficiary simply wants what was supposed to have been distributed under the plan, the appropriate remedy is

§ 502 (a)(1)(B). *See, e.g., Cathey v. Dow Chemical Co. Medical Care Program*, 907 F.2d 554, 555 (5th Cir. 1990), *cert. denied*, 111 S. Ct. 964 (1991). Damages that would give a beneficiary more than he or she is entitled to receive under the strict terms of the plan are typically termed "extracontractual." Section 502(a)(3) by its terms permits beneficiaries to obtain "other appropriate equitable relief" to redress (1) a violation of the substantive provisions of ERISA or (2) a violation of the terms of the plan. Although the Corcorans have neither identified which of these two types of violations they seek to redress nor directed us to the particular section of the Plan or ERISA which they claim was violated, we need not determine this in order to resolve the issue before us. As outlined below, we find that the particular damages the Corcorans seek — money for emotional injuries — would not be an available form of damages under the trust and contract law principles which, the Corcorans urge, should guide our interpretation of ERISA's remedial scheme. Thus, we hold that even under the interpretation of § 502(a)(3) urged by the Corcorans, they may not recover.

The question whether extracontractual or punitive damages are available to a beneficiary under § 502(a)(3) has been left open by the Supreme Court ever since *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985). In *Russell*, the beneficiary of a plant sought compensatory and punitive damages under ERISA §§ 502(a)(2) and 409(a)[17] for the improper processing of her claim for disability benefits. *Id.* at 136, 138. The Court rejected the argument that such damages were available under § 409(a), holding that §409(a) (1) authorized only actions on behalf of the plan as a whole, not individual

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[17] Section 502(a)(2) permits "the Secretary. . .a participant, beneficiary or fiduciary" to sue for appropriate relief under § 409.

beneficiaries, for losses to the plan; and (2) provided no implied cause of action for extracontractual damages caused by improper claims processing. *Russell*, 473 U.S. at 140, 147. Because the beneficiary expressly disclaimed reliance on § 502(a)(3), however, the Court had no occasion to consider whether the damages the plaintiff sought were available under that section. *Id.* at 139 n.5.

In a concurrence joined by three other Justices, Justice Brennan emphasized that he read the court's reasoning to apply only to § 409(a), and that the legislative history of ERISA suggested that courts should develop a federal common law in fashioning "other appropriate equitable relief" under § 502(a)(3). *Id.* at 155-56 (Brennan, J., concurring in the judgment). Justice Brennan argued that Congress "intended to engraft trust-law principles onto the enforcement scheme" of ERISA, including the principle that courts should give to beneficiaries of a trust the remedies necessary for the protection of their interests. *Id.* at 156-57. Consequently, he encouraged courts faced with claims for extracontractual damages first to determine to what extent state and federal trust and pension law provide for the recovery of damages beyond any benefits that have been withheld, and second to consider whether extracontractual relief would conflict with ERISA in any way. *Id.* at 157-58. With respect to the first inquiry he indicated that any deficiency in trust law in the availability of make-whole remedies should not deter courts from authorizing such remedies under § 502(a)(3), for Congress intended in ERISA to strengthen the requirements of the common law of trusts as they relate to employee benefit plans. *Id.* at 157 n.17. Finally, Justice Brennan suggested, courts should keep in mind that the purpose of ERISA is the "enforcement of strict fiduciary standards of care in the administration of all aspects of pension plans and promotion of the best interests of participants and

beneficiaries." *Id.* at 158.

The Corcorans urge us to apply Justice Brennan's concurrence and hold that the damages they seek amount to "other appropriate equitable relief." The defendants, on the other hand, urge us to interpret "other appropriate equitable relief" to include only declaratory and injunctive relief. Under the defendants' view of § 502(a) (3), which has been adopted by a number of circuits,[18] no money damages would be awardable and our discussion would be at an end. However, even assuming that Justice Brennan's view of "other appropriate equitable relief" as potentially encompassing make-whole relief is a proper construction of that section, the damages the Corcorans seek would not be available.

The characterization of equitable relief as encompassing damages necessary to make the plaintiff whole may well be consistent with the trust law principles that were incorporated into ERISA and which guide its interpretation. *See Firestone,* 489 U.S. at 110-11 (because ERISA is largely based on trust law, those principles guide interpretation); H.R. Rep. No. 533, 93d Cong., 1st Sess. (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639; S. Rep. No. 127, 93d Cong., 1st Sess., *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838 (indicating intent to incorporate the law of trusts into ERISA). Section 205 of the Restatement (Second) of Trusts allows for monetary damages as make-whole relief, providing that a beneficiary has "the option of pursuing a remedy which will

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[18] *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821 (1st Cir.), *cert. denied*, 488 U.S. 909 (1988); *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir. 1992), *petition for cert. filed*, 60 U.S.L.W. 3816 (U.S. May 11, 1992) (No. 91-1835); *Novak v. Andersen Corp.*, No. 91-1957 (8th Cir. April 9, 1992); *Sokol v. Bernstein*, 803 F.2d 532 (9th Cir. 1986); *Bishop v. Osborn Transp., Inc.*, 838 F.2d 1173 (11th Cir.), *cert. denied*, 488 U.S. 832 (1988).

put him in the position in which he was before the trustee committed the breach of trust" or "of pursuing a remedy which will put him in the position in which he would have been if the trustee had not committed the breach of trust." In the context of the breach of a trustee's investment duties, "the general rule [is] that the object of damages is to make the injured party whole, that is, to put him in the same condition in which he would have been if the wrong had not been committed. . . .Both direct and consequential damages may be awarded." G. Bogert & G. Bogert, *The Law of Trusts and Trustees* § 701, at 198 (2d ed. 1982). *See also Estate of Talbot*, 141 Cal. App. 309, 296 P.2d 848 (1956); *In re Cook's Will*, 136 N.J. Eg. 123, 40 A.2d 805 (1945).

This view may also be consistent with the common law contract doctrine which assists us in interpreting ERISA. As the Court observed in *Russell*, ERISA was enacted "to protect contractually defined benefits." 473 U.S. at 148. Prior to the enactment of ERISA, the rights and obligations of pension beneficiaries and trustees were governed not only by trust principles, but in large part by contract law. *Firestone*, 489 U.S. at 112-13; *see also Rochester Corp. v. Rochester*, 450 F.2d 118, 120-21 (4th Cir. 1971); *Audio Fidelity Corp. v. Pension Benefit Guaranty Corp.*, 624 F.2d 513, 517 (4th Cir. 1980); *Hoefel v. Atlas Tack Corp.*, 581 F.2d 1, 4-7 (1st Cir. 1978). It is well-established that contract law enables an aggrieved party to recover such damages as would place him in the position he would have occupied had the contract been performed, Restatement (Second) of Contracts § 347 & comment a (1981), including those damages that could reasonably have been foreseen to flow from the breach. *Id.* § 351; *see Warren v. Society Nat. Bank*, 905 F.2d 975, 980 (th Cir. 1990) (§ 502 (a)(3) allows for recovery of beneficiaries' increased tax liability after plan administrators failed to

follow instructions regarding distribution), *cert. denied*, 111 S. Ct. 2556 (1991).

However, the Corcorans seek a form of extracontractual damages that is never, as far as we can tell, awarded for breach of trust duties, and is granted only in the most limited of circumstances for a breach of contract. Certainly, patients and their physicians can enter into contracts and physicians may incur liability for breach. The cases are uniform, however, in holding that there can be no recovery against a physician on a contractual theory, as opposed to the usual recovery on a tort theory of medical negligence, unless there is an express agreement to perform a particular service or to achieve a specific cure. E.g., Bobrick v. Bravstein, 497 N.Y.S.2d 749, 751, 116 A.D.2d 682 (App. Div. 1986); *Cirafici v. Goffen*, 85 Ill. App. 3d 1102, 407 N.E.2d 633, 635, 41 Ill. Dec. 135 (1980); *Depenbrok v. Kaiser Foundation Health Plan, Inc.*, 79 Cal. App. 3d 167, 144 Cal. Rptr. 724, 726 (1978). In a few cases, courts, recognizing a distinction between commercial contracts and contracts for the performance of personal services, have found inapplicable the general rule that emotional distress damages are not available in contract actions[19] and have allowed damages for emotional injuries within the contemplation of the parties. *Stewart v. Rudner*, 349 Mich. 459, 84 N.W.2d 816, 824 (1957) ("the parties may reasonably be said to have contracted with reference to the payment of [emotional distress] damages therefor in event of breach"); *Sullivan v. O'Connor*, 363 Mass. 579, 296 N.E.2d 183, 188-89 (1973) (although mental anguish damages are not available for breach of a commercial contract, psychological injury may be contemplated in a con-

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[19] *See* J. Calamari & J. Perillo, *The Law of Contracts* §§ 14-3, 14-5(b), at 595-96 (3d ed. 1987); 11 W. Jaeger, *Williston on Contracts* § 1341, at 214 (3d ed. 1968); 5 *Corbin on Contracts* § 1076, at 426 (2d ed. 1964).

tract for an operation) (citing *Stewart*). The *Stewart* rule, however, has not been widely adopted, and the Michigan courts recently have characterized its holding concerning damages as applying only to contracts involving deep, personal relationships, *Chrum v. Charles Heating & Cooling, Inc.*, 121 Mich. App. 17, 327 N.W.2d 568, 570 (1982), and contracts to perform very specific acts. *Penner v. Seaway Hosp.*, 169 Mich. App. 502, 427 N.W.2d 584, 587 (1988).

The strictness with which courts have viewed doctor-patient contracts thwarts the Corcorans' claim that emotional distress damages would be available here under a make-whole interpretation of § 502(a)(3). The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best. Related to this problem is the lack of an express agreement for a particular service or for a particular result that serves as a prerequisite to a contract-based recovery. Even assuming that United's booklet could be considered an aspect of the "plan," breach of which would give rise to a cause of action under § 502(a)(3), it cannot be construed as making an agreement to perform any particular medical procedure or to arrive at any result. At most it makes promises to act in accordance with accepted standards of medical care. But courts have not recognized these sorts of promises as creating contractual duties between physicians and patients. *Cirafici*, 407 N.E.2d at 635-36 (failure to perform with requisite skill and care leads to action for negligence, not breach of contract); *Awkerman v. Tri-County Orthopedic Group, P.C.*, 143 Mich. App. 722, 373 N.W.2d 204, 206 (1985) (physician's breach of express or implied promise to act in accordance with standard of care not actionable in contract). Indeed, the Massachusetts Supreme Judicial Court has emphasized that in an action seeking damages under *Sullivan*, one of

the leading cases allowing mental distress damages for a breached medical contract, recovery is not for the doctor's failure to live up to the standard of care but solely for a failure to perform the specific promise contained in the agreement. *Salem Orthopedic Surgeons, Inc. v. Quinn*, 377 Mass. 514, 386 N.E.2d 1268, 1271 (1979). *See also Murray v. University of Pennsylvania Hosp.*, 490 A.2d 839, 841 (Pa. Super. 1985) (action for breach of contract to achieve particular result may lie even if doctor has exercised highest degree of skill and care).

The fact that courts regularly view doctors and their patients as standing in a fiduciary relationship, *e.g.*, *Black v. Littlejohn*, 312 N.C. 626, 325 S.E.2d 469, 482 (1985); *Liebergesell v. Evans*, 93 Wash. 2d 881, 613 P.2d 1170, 1176 (1980); *State ex rel. Stufflebaum v. Appelquist*, 694 S.W.2d 882, 885 (Mo. App. 1985), also is of no avail. Although a plan beneficiary certainly may sue under § 502(a)(3) for a breach of the fiduciary duties set forth in § 404, the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines this ground of recovery. In any event, courts have not held that patients may sue their doctors under any independent "breach of fiduciary duty" theory. The remedies are limited to contract actions (where an express agreement has been made) and, in the vast majority of cases, tort actions for negligence. Assuming without deciding, therefore, that § 502(a)(3) permits the award of make-whole relief as "other appropriate equitable relief," we hold that the emotional distress and mental anguish damages sought here by the Corcorans are not recoverable.

* * *

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what

may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, If the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs.[20] ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.

Second, in any plan benefit determination, there is always some tension between the interest of the beneficiary in obtaining quality medical care and the interest of the plan in preserving the pool of funds available to compensate all beneficiaries. In a prospective review context, with its greatly increased ability to deter the beneficiary (correctly or not) from embarking on a course of treatment recommended by the beneficiary's physician, the tension between interest of the beneficiary and that of the plan is exacerbated. A system which would, at least in some circumstances, compensate the beneficiary who changes course based upon a wrong call for at least some of the

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[20] We note that, were the Corcorans able to recover against United under state law, the contract between Bell and United indicates that United would bear the cost. However, the general application of a liability system to utilization review companies would ultimately result in increased costs to plans such as the Bell plan as it became more expensive for companies such as United to do business.

costs of that call might ease the tension between the conflicting interests of the beneficiary and the plan.

Finally, cost containment features such as the one at issue in this case did not exist when Congress passed ERISA. While we are confident that the result we have reached is faithful to Congress's intent neither to allow state-law causes of action that relate to employee benefit plans nor to provide beneficiaries in the Corcorans' position with a remedy under ERISA, the world of employee benefit plans has hardly remained static since 1974. Fundamental changes such as the widespread institution of utilization review would seem to warrant a reevaluation of ERISA so that it can continue to serve its noble purpose of safeguarding the interests of employees. Our system, of course, allocates this task to Congress, not the courts, and we acknowledge our role today by interpreting ERISA in a manner consistent with the expressed intentions of its creators.

V. *CONCLUSION*

For all the foregoing reasons, we find that ERISA pre-empts the Corcorans' tort claim against United and that the Corcorans may not recover damages for emotional distress under § 502(a)(3) of ERISA. Accordingly, the judgment of the district court is AFFIRMED.

APPENDIX B

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Filed
MAR 8 91

FLORENCE B. CORCORAN and WAYNE D. CORCORAN	Civil Action
VERSUS	No. 90-4303
UNITED HEALTHCARE, INC. and BLUE CROSS AND BLUE SHIELD OF ALABAMA, INC.	Section "J"

JUDGMENT

Considering the Order and Reasons of March 7, 1991,

IT IS HEREBY ADJUDGED, ORDERED, AND DECREED that there is judgment against the plaintiffs (Florence B. Corcoran and Wayne D. Corcoran) and in favor of the defendants (United HealthCare, Inc. and Blue Cross and Blue Shield of Alabama, Inc.), dismissing the plaintiffs' complaint at the plaintiffs' costs.

New Orleans, Louisiana, this 7th day of March, 1991.

/s/ Patrick E. Carr
UNITED STATES DISTRICT JUDGE

ph

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DATE OF ENTRY MAR 8 1991

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

Filed
MAR 8 91

FLORENCE B. CORCORAN and WAYNE D. CORCORAN	Civil Action
VERSUS	No. 90-4303
UNITED HEALTHCARE, INC. and BLUE CROSS AND BLUE SHIELD OF ALABAMA, INC.	Section "J"

Order and Reasons

CARR, J.

This matter came before the Court on February 27, 1991 for hearing on the defendants' motion for summary judgment [Record Document No. 7]. The Court took the motion under submission and now GRANTS the motion.

This action concerns the interplay betweeen a state wrongful death claim and ERISA, 29 U.S.C. §§ 1001-1461. The sole issue before the Court is the legal issue whether the plaintiffs' action relates to the plaintiffs' ERISA-governed group health plan. All agree that if the answer is yes, then the plaintiffs' entire complaint is preempted by ERISA and that if the answer is no, then ERISA provides no impediment to the plaintiffs' complaint.

I.

The material facts are undisputed, at least for

DATE OF ENTRY MAR 8 1991

purposes of this motion. Florence Corcoran works for South Central Bell Telephone Company and is covered by its self-funded group health plan, which is governed by ERISA. Defendant Blue Cross and Blue Shield of Alabama, Inc. is the claims administrator under the plan; defendant United HealthCare, Inc. is the delegated administrator of the "Quality Care Program" provisions in the plan. Among other things, the plan provides: "To receive maximum Plan benefits, [a plan participant such as Mrs. Corcoran] must comply with Quality Care Program (QCP) requirements." *See* Exh. B, at 16, *attached to* Defendants' Motion for Summary Judgment. Essentially, the QCP requires approval from United HealthCare for certain medical care before the plan will fully cover the expenses for that care. To operate the QCP, United HealthCare often seeks independent medical advice as to the necessity and cost of the health care for which a plan participant seeks coverage under the plan.

In 1989, Mrs. Corcoran became pregnant. Her doctor, Dr. Jason H. Collins, diagnosed her as suffering certain medical conditions that might complicate her pregnancy. Both Dr. Collins and Mrs. Corcoran contacted United HealthCare about its approving certain in-patient hospital care that Dr. Collins believed Mrs. Corcoran needed in the last months of her pregnancy; according to Dr. Collins, he believed that Mrs. Corcoran should be hospitalized the last months of her pregnancy so that he could monitor the fetus on a 24-hour-a-day basis. While a doctor reviewing Mrs. Corcoran's medical history and records for United HealthCare allegedly concurred that her "pregnancy was risky," United HealthCare refused to authorize coverage for 24-hour-per-day hospitalization, but did approve limited home-nursing care. The plaintiffs do not allege, and present no evidence, that any doctor or other person on behalf of United HealthCare performed a physical diagnosis on Mrs.

Corcoran or ever personally saw or spoke to Mrs. Corcoran.

Presumably—at least in part—because United HealthCare refused to authorize coverage for round-the-clock hospitalization, Mrs. Corcoran forwent hospitalization during the last months of her pregnancy and instead remained at home and received the nursing care for which United HealthCare had authorized full payment.

On October 25, 1989, during a portion of the day when no nurse was at Mrs. Corcoran's home, the unborn baby allegedly "went into fetal distress ... and died."

Mr. and Mrs. Corcoran sued United HealthCare and Blue Cross in Louisiana state court. The plaintiffs allege that Blue Cross was negligent in (1) "wrongfully denying appropriate medical care" to Mrs. Corcoran, (2) failing to adequately oversee United HealthCare, and (3) failing to provide United HealthCare a complete medical history on Mrs. Corcoran. The plaintiffs allege that United HealthCare was negligent in (1) "wrongfully denying appropriate medical care" to Mrs. Corcoran, (2) "wrongfully determining that home nursing care was adequate medical care," and (3) "failing to authorize the care recommended by her doctor." The plaintiffs seek damages under Louisiana Civil Code article 2315 for loss of love, affection, and society of their unborn child and for mental pain and anguish. The plaintiffs concede that the defendants have fully paid all medical expenses that Mrs. Corcoran actually incurred that were covered by the plan.

The defendants removed the action to this Court on the basis of both diversity and ERISA federal question. Contending that the plaintiffs' claims are wholly preempted by ERISA, the defendants now move for summary

judgment on that basis alone.[1]

II.

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" governed by ERISA. As the Supreme Court has recently emphasized, this preemption clause includes " 'deliberately expansive' language" and "is conspicuous for its breadth." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. ____, ____, 111 S. Ct. 478, 482, 112 L.Ed.2d 474 (1990); *FMC Corp. v. Holliday*, 498 U.S. ____, ____, 111 S. Ct. 403, 407, 112 L.Ed.2d 559 (1990). ERISA preempts "any state law claim that relates to an employee benefit plan, even if the action arises under general state law that in and of itself has no impact on employee benefit plans." *Lee v. E.I. DuPont de Nemours & Co.*, 894 F.2d 755, 756 (5th Cir. 1990).

"[A] law relates to an employee [health] plan if it has 'a connection with or a reference to such a plan.' " *FMC Corp.*, 498 U.S. at ____, 111 S. Ct. at 407 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2899-900, 77 L.Ed.2d 490 (1983)). This ERISA preemption extends to state law claims "of general application," in-

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[1] The Court is not being asked to decide, and does not now decide, (1) whether, as a matter of Louisiana state tort law, the doctor-patient duty at issue in *Green v. Walker*, 910 F.2d 291 (5th Cir. 1990), should extend to the factual scenario here notwithstanding the health plan's specific, bold-faced warnings that all health care decisions were for the plan participant and her treating doctors to make, *see* Exh. B, at 22, 24, *attached to* Defendants' Motion for Summary Judgment, and notwithstanding that no one on behalf of the defendants ever diagnosed or even saw Mrs. Corcoran or (2) whether, even assuming *Green* should so extend, defendant Blue Cross, which was not the designated administrator of the plan's QCP, could be held liable under state law.

cluding tort claims where ERISA ordinarily plays no role in the state law at issue. *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58, 62, 107 S. Ct. 1542, 1546, 95 L.Ed.2d 55 (1987) (citing *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 48-51, 107 S. Ct. 1549, 1553-55, 95 L.Ed.2d 39 (1987)); *see, e.g., Brock v. Primedica, Inc.*, 904 F.2d 295, 297 (5th Cir. 1990) (on tort claims of mental anguish and emotional distress); *Lee* 894 F.2d at 756 (on state law fraud and negligent misrepresentation claims). In other words, "a state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." *Ingersoll-Rand*, 498 U.S. at ____, 111 S. Ct. at 483.

Further, this preemption applies not only for claims against the plan itself, but also for claims against the plan's various administrators. *See, e.g., Boren v. N.L. Industires, Inc.*, 889 F.2d 1463, 1466 (5th Cir. 1989), *cert. denied*, ____, U.S. ____, 110 S. Ct. 3283, 111 L.Ed.2d 792 (1990).

III.

Here, the existence of the ERISA plan "is a critical factor in establishing liability under" the plaintiffs' would-be state-law malpractice claim. *Cf. Ingersoll-Rand*, 498 U.S. at ____, 111 S. Ct. at 483. But for the ERISA plan, the defendants would have played no part in Mrs. Corcoran's pregnancy; the sole reason the defendants had anything to do with her pregnancy is because the terms of the ERISA plan directed Mrs. Corcoran to the defendants (or at least to United HealthCare) for approval of coverage of the medical care she initially sought.

Without the ERISA plan, the plaintiffs could not establish—as an issue of fact—that the defendants

breached any duty to them, for the source of the defendants' obligations arose from the ERISA plan itself (indeed, the plaintiffs implicitly recognize this fact, for their state-court petition specifically describes the plan and the defendants' roles under the plan). *Contrast, e.g., Schultz v. National Coalition of Hispanic Mental Health and Human Services Organizations,* 678 F. Supp. 936 (D.D.C. 1988); *Morningstar v. Meijer, Inc.,* 662 F. Supp. 555 (E.D. Mich. 1987). "As a result, this cause of action relates not merely to [health] benefits, but to the essence of the [health] plan itself." *Ingersoll-Rand,* 498 U.S. at ____, 111 S. Ct. at 483 (emphasis in original).

The plaintiffs attempt to distinguish the defendants' role in paying claims to Mrs. Corcoran from their alleged "doctor-patient" role in deciding whether certain medical care was appropriate for Mrs. Corcoran. Any such distinction here, however, is immaterial, for the plaintiffs ignore the source of the alleged doctor-patient relationship between Mrs. Corcoran and the defendants: the ERISA plan, which authorized and directed the defendants to review Mrs. Corcoran's medical condition and records.

The principal case relied upon by the plaintiffs, *Pickett v. CIGNA HealthPlan of Texas,* 742 F. Supp. 946 (S.D. Tex. 1990), has no application here. There, CIGNA was the plan administrator for the plaintiff's ERISA health plan; the plaintiff brought a state-law malpractice action for alleged injuries he suffered while seeking treatment in a health maintenance organization (HMO) that coincidentally CIGNA operated in a capacity wholly separate from its capacity as an ERISA plan administrator. Because the plaintiff's ERISA plan played no part in his claim against CIGNA and various of its doctors in the HMO (e.g., there is no hint that the ERISA plan required that the plaintiff seek care from this HMO), the

Court concluded that ERISA did not preempt the plaintiff's malpractice claim. Here, by contrast, Mrs. Corcoran's ERISA plan is central to her malpractice claim: without the ERISA plan, the defendants here would not have reviewed Mrs. Corcoran's medical condition and thus no alleged malpractice by the defendants could possibly have occurred.

Directly affecting the relationship between the plan's administrators and beneficiaries, specifically, between the defendants and the plaintiffs, the state tort law of malpractice "*as applied in this case*" does not "affect[ ] [the] benefit plan[ ] in too tenuous, remote, and peripheral a manner [not] to warrant a finding that it 'relate[s] to' the plan[ ]." *Contrast Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1467-70 (5th Cir.), *reh'g & reh'g en banc denied mem.*, 797 F.2d 977 (5th Cir. 1986), *cert. denied sub nom. Corrigan v. Sommers Drug Stores Co.*, 479 U.S. 1034, 107 S. Ct. 884, 93 L.Ed.2d 837 (1987) *and cert. denied sub nom. Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*, 479 U.S. 1089, 107 S. Ct. 1298, 94 L.Ed.2d 154 (1987).

In sum, the Court holds that the plaintiffs' complaint relates to Mrs. Corcoran's ERISA plan and thus is preempted by ERISA. Because the plaintiffs concede that the defendants have fully paid any and all medical expenses that Mrs. Corcoran actually incurred that were covered by the plan, the plaintiffs have no remaining claims under ERISA.[2] Thus, the plaintiffs' entire action should be

---

[2] Before going into the hospital, Mrs. Corcoran could have sued United Health Care for a declaratory judgment under ERISA that she was entitled under the plan to have covereage for her doctor's recommended hospital care. Alternitively, she could have chosen to go into the hospital and then have sued under ERISA IV coverage of the expenses

dismissed with prejudice.

IV.

For these reasons, the Court dismissss th plaintiffs' complaint with prejudice at their costs

New Orleans, Louisiana, this 7th day of March, 1991.

/s/Patrick E. Carr
UNITED STATES DISTRICT JUDGE

ph

Footnote 2 continued.

she incurred. *Cf. Cathey v. Dow Chemical Co. Medical Care Program*, 907 F.2d 554 (5th Cir. 1990), *cert. denied*, ___ U.S. ___ 111 S.Ct. ___, ___ L.Ed.2d ___, 59 U.S.L.W. 3562 (Feb. 15, 1991). She chose neither alternative.

APPENDIX C

APR 04 1991

FILED
APR 3 91

FLORENCE B. CORCORAN and
WAYNE D. CORCORAN — Civil Action

VERSUS — No. 90-4303

UNITED HEALTHCARE, INC.
and BLUE CROSS AND BLUE
SHIELD OF ALABAMA, INC. — Section "J"

This matter is the Court on the plaintiffs' motion for "reconsideration" pursuant F.R.Civ.P. 59 [Record Document No. 21].

Determining that oral argument is not needed, the Court CANCELS the hearing on the motion, previously set for April 3, 1991, and now DENIES the motion.

The plaintiffs contend that section 509 (a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), permits them to recover extracontractual compensatory and consequential damages. In support, they cite the concurring opinion in *Massachussetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S. Ct. 3085, 87 L.Ed.2d 96 (1985); a paragraph of dictum in a case solely on the amount an administrator owed a widow under her husband's retirement plan, *Lorenzen v. Employees Retirement Plan of Sperry & Hutchinson Co.*, 896 F.2d 228, 230 (7th Cir. 1990) (2-1); and a case where the plan administrator allegedly disobeyed,

DATE OF ENTRY APR 3 1991

contrary to the plan provisions, the plaintiff's instructions on how to administer his retirement fund, *Warren v. Society National Bank*, 905 F.2d 975 (6th Cir.), *cert. filed*, No. 90-870 (1990).

The vast majority of federal appellate courts have rejected the *Russell* concurrence and held that a beneficiary under an ERISA health plan may not recover under section 509(a)(3) of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan. *See McRae v. Seafarers' Welfare Plan*, 920 F.2d 819, 821-22 & n.8 (11th Cir. 1991) (Wisdom, J.) (collecting cases, including *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1462-64 (5th Cir.), *reh'g & reh'g en banc denied mem.*, 797 F.2d 977 (5th Cir. 1986), *cert. denied sub nom. Corrigan v. Sommers Drug Stores Co.*, 479 U.S. 1034, 107 S. Ct. 884, 93 L.Ed.2d 837 (1987) *and cert. denied sub nom. Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan*, 479 U.S. 1089, 107 S. Ct. 1298, 94 L.Ed.2d 154 (1987)). These cases are persuasive. Further, the Tenth Circuit has recently held that section 509(a)(3) of ERISA does not permit a plaintiff to sue for wrongful death from denial of health benefits where, as here, the state-law wrongful death claim is preempted by ERISA. *See Settles v. Golden Rule Insurance Co.*, ____ F.2d ____, 1991 WL 26223, at *5 (10th Cir. Mar. 5, 1991) (No. 89-3242((citing *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1297 (5th Cir. 1989)).

The concern the plaintiffs, following the *Russell* concurrence, note—the possibility of some wrong by a plan administrator to a plan beneficiary that is not covered by ERISA—is, in any event, not at issue here: the plaintiffs here were not without a remedy when United HealthCare informed them that it would not authorize 24-hour-a-day

hospital care. As the Court noted in footnote 2 of its Order and Reasons, Mrs. Corcoran could have (1) immediately sued for an expedited declaratory judgment that she was entitled to coverage for such care under the plan or (2) nonetheless chosen to go into a hospital and thereafter sued under ERISA for coverage of the expenses she had incurred.

The plaintiffs' position also fails for another reason, even ignoring the question what damages may be recoverable for an ERISA violation: the plaintiffs can show no duty that the defendants allegedly breached under ERISA. On the one hand, the plaintiffs' state-law wrongful death claim is preempted by ERISA, and ERISA itself does not provide that, irrespective of the terms of a health policy, a doctor-patient relationship is always deemed to exist between a plan beneficiary and a plan administrator. On the other hand, the ERISA plan here concerned only the payment, not the medical propriety, of health care expenses and expressly provided that no such doctor-patient relationship was created by the plan: the plan contained specific warnings that all health care decisions were for the plan participant and her treating doctors to make, *see, e.g.*, Exh B at 22, 24, *attached to* Defendant's Motion for Summary Judgment.

- - - - - -

/s/ P. E. Carr

ph

APPENDIX D

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provisions of this

subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (c)(2) or (i) or (*l*) of this section.

APPENDIX E

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

APPENDIX F

C.C. Art. 2315 **Book III**

MODES OF ACQUIRING OWNERSHIP OF THINGS

CHAPTER 2—OF OFFENSES AND QUASI OFFENSES

Art. 2315. Liability for acts causing damages

Every act whatever of man that causes damage to another obliges him by whose fault it happened to repair it.

Damages may include loss of consortium, service, and society, and shall be recoverable by the same respective categories of persons who would have had a cause of action for wrongful death of an injured person.

Supreme Court, U.S.
FILED
NOV 25 1992
OFFICE OF THE CLERK

No. 92-547

In The

Supreme Court of the United States

October Term, 1992

FLORENCE B. CORCORAN, WIFE OF/AND
WAYNE D. CORCORAN,

Petitioners,

versus

UNITED HEALTHCARE, INC AND BLUE CROSS
AND BLUE SHIELD OF ALABAMA, INC.,

Respondents.

**Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Fifth Circuit**

BRIEF IN OPPOSITION TO THE PETITION FOR WRIT OF CERTIORARI

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54 pp

QUESTIONS PRESENTED FOR REVIEW

(1) Whether the Fifth Circuit Court of Appeals correctly decided that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq.*, preempts state law claims, including claims for wrongful death and medical malpractice, against administrators of an ERISA plan who were acting in their capacity as plan administrators.

(2) Whether the Fifth Circuit Court of Appeals correctly decided that, assuming (a) Petitioner stated a claim under ERISA Section 502(a)(3)(B), 29 U.S.C. § 1132(a)(3)(B), and (b) this provision allowed recovery of extracontractual money damages as equitable relief, ERISA did not authorize emotional distress and mental anguish damages against a plan administrator.

LIST OF ALL PARTIES TO THE PROCEEDINGS BELOW

Florence B. Corcoran

Wayne D. Corcoran

United HealthCare, Inc.

Blue Cross and Blue Shield of Alabama, Inc.[1]

---

[1] Pursuant to Sup.Ct.R. 29.1, Respondents inform the Court that United HealthCare, Inc. has no parent companies or nonwholly owned subsidiaries, and Blue Cross and Blue Shield of Alabama, Inc. has no parent companies or nonwholly owned subsidiaries.

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STATEMENT OF THE CASE

A. STATEMENT OF FACTS[2]

Petitioner, Florence B. Corcoran,[3] is an employee of South Central Bell Telephone Company entitled to certain medical and hospitalization benefits under the BellSouth Medical Assistance Plan (the "Plan"), a self-funded ERISA welfare benefit plan. BellSouth Corporation is the Plan Sponsor and Administrator. Various BellSouth subsidiaries, including South Central Bell, participate in the Plan. Pursuant to express Plan authority, BellSouth designated Blue Cross and Blue Shield of Alabama, Inc. ("Blue Cross") as the Claims Administrator, and United HealthCare, Inc. ("United") as the administrator of the Quality Care Program, a component of the Plan. As Plan Administrators, Blue Cross and United are ERISA fiduciaries.[4]

The linchpin of Petitioner's argument throughout these proceedings has been that the relationship between Petitioner and United is similar to the relationship between physician and patient, and that Petitioner's claims are based entirely on United's alleged medical negligence. This is untrue. Petitioner has admitted that the only relationship between Petitioner and United was the result of Petitioner's status as a Plan participant and

---

[2] Because Respondents take issue with Petitioners' presentation of the facts of this case, Respondents set forth the "Statement of Facts" in order to preserve their right to contest Petitioners' version. *See* Sup.Ct.R. 15.1.

[3] Respondents will refer to Ms. Corcoran as "Petitioner." Respondents will not discuss Mr. Corcoran's claims separately, as they are entirely dependent upon the claims of Ms. Corcoran. Respondents expressly make any statement regarding Ms. Corcoran's claims equally applicable to those of Mr. Corcoran.

[4] As the Fifth Circuit noted, Petitioners challenge only findings regarding their claims against United. The Petition to this Court also refers only to United.

United's fulfillment of its responsibilities as the administrator of the Quality Care Program. (Appellees' Rec. Exc., p. 010, ¶ 31).[5] The District Court held as a matter of law that the Plan documents unambiguously refuted any claim that United acted as Petitioner's physician. Petitioners' Appendix ("Pet. App.") at A-50. The Fifth Circuit held United makes medical decisions only in the context of making benefits determinations under the Plan. 965 F.2d at 1331, Pet. App. at A-21.

United's responsibilities under the Plan are to determine what benefits will be paid for a participant's treatment, as set forth in an explanatory booklet concerning the Quality Care Program ("Explanatory Booklet") (Appellants' Rec. Exc., No. 5) and in the Summary Plan Description ("SPD") (Appellees' Rec. Exc., p. 028), which were both given to Petitioner. The Explanatory Booklet describes United's role as follows:

> Basically, QCP [Quality Care Program] works directly with your doctor. If your doctor recommends that you have surgery or go into the hospital for some kind of treatment, he or she simply telephones United HealthCare on a toll-free number and discusses your condition with a staff member. United will then advise your doctor what the medical plan will pay for, based on a review of your clinical information and nationally accepted medical guidelines for the treatment of your condition.

(Appellants' Rec. Exc., p. 16).

The Explanatory Booklet specifically tells the participant United is not her physician:

> In contrast, Quality Care is not:
>
> an attempt to limit your access to health care. You can always get any kind of treatment that

---

[5] References are to the Record Excerpts filed with the Fifth Circuit Court of Appeals by Petitioners herein ("Appellants' Rec. Exc.") and by Respondents herein ("Appellees' Rec. Exc.").

> you wish. However, you may have to pay a portion of the cost.
>
> an attempt to interfere in the relationship between you and your doctor. You are free to consult any physician you wish.

(Appellants' Rec. Exc., p. 17).

The Explanatory Booklet explains that the consequence of not using United's services is that benefits under the Plan are reduced by 20% up to a maximum of $1,250. (Appellants' Rec. Exc., p. 20). Petitioner was specifically advised in the Explanatory Booklet that she is not required to use United's services and that she can "always get any kind of treatment that you wish", but that, "[h]owever, you may have to pay a portion of the cost."

To support the incorrect premise of this lawsuit, the existence of a physician-patient relationship between United and Petitioner, Petitioner cites portions of the booklet which state United is an independent professional medical review organization and discuss its professional staff. Pet. Brief at 3. These positive descriptions of United's professional nature are hardly sufficient to prove United was Petitioner's physician. Petitioner also points to some language discussing the unnecessary surgeries that occur in the United States. Pet. Brief at 3-4. This discussion, however, is in the context of explaining "runaway health care costs." (Appellants' Rec. Exc., p. 16-17). These statements are followed by the explicit provision that the program is not an attempt to limit Petitioner's access to health care or to interfere in the relationship between Petitioner and her doctor. (Appellants' Rec. Exc., p. 17).

The nature of the relationship between Petitioner and United is similarly explained in the SPD which was provided to Petitioner (Appellees' Rec. Exc., p. 003, ¶ 8):

> The Quality Care Program (QCP), administered by United HealthCare, Inc., assists you and vour covered dependents in securing quality medical

> care according to the provisions of the Plan while helping reduce risk and expense due to unnecessary hospitalization and surgery. They do this by providing you with information which will permit you (in consultation with your doctor) to evaluate alternatives to surgery and hospitalization when those alternatives are medically appropriate. In addition, QCP will monitor any certified hospital confinement to keep you informed as to whether or not the stay is covered by the Plan.
>
> * * *
>
> **When reading this booklet, remember that all decisions regarding your medical care are up to you and your doctor.**[6]

(Appellees' Rec. Exc., p. 029).

The SPD also explains that the consequences of not following the procedures with United are that Petitioner might have to pay 20% of the benefits from her own pocket, up to $1250. (Appellees' Rec. Exc., p. 029-30). If a claim for benefits is denied, the Plan sets forth appeal procedures (Appellees' Rec. Exc., p. 031).

Pursuant to the Quality Care Program procedures, when Ms. Corcoran was diagnosed during her pregnancy as having high blood pressure and preeclampsia, she and her doctor, Dr. Jason Collins, contacted United concerning her medical care and hospitalization benefits under the Plan. Petitioner admitted in the District Court that the purpose of Dr. Collins's call to United was to determine her Plan benefits. This was set forth in the Statement of Uncontested Material Facts as follows:

---

[6] This statement is repeated in the SPD, at the end of the introductory explanation of the Quality Care Program, in bold print. (Appellees' Rec. Exc., p. 030).

> Pursuant to the Quality Care Program procedures set forth in the Summary Plan Description, when Ms. Corcoran became pregnant in 1989 and was diagnosed by her doctor, Dr. Jason Collins, as having high blood pressure and preeclampsia, United HealthCare was contacted by Dr. Collins and by Ms. Corcoran concerning her medical care and hospitalization benefits under the Plan. (Affidavit of Donna Armer).

(Appellees' Rec. Exc., p. 010, ¶ 30).

Petitioner also admitted in the District Court that her claims all relate to the ERISA plan:

> Plaintiffs' claims that United HealthCare and Blue Cross negligently deprived Ms. Corcoran of medical care, or hospitalization or otherwise engaged in negligent acts as administrators of the BellSouth Medical Assistance Plan all have a connection with or reference to the Plan and therefore relate to the Plan.

(Appellees' Rec. Exc., p. 010-11, ¶ 32).

In her Petition to this Court, Petitioner states, "the suit was not premised on improper claims processing or coverage determination, but rather upon United HealthCare's negligence in failing to determine the appropriate medical care for Mrs. Corcoran." Pet. Brief at 5-6. Regardless of how Petitioner characterizes her claim, the undisputed facts establish that her complaint is directed at United, a fiduciary and administrator of the Plan; complains about actions by United in its capacity as plan administrator; and complains about specific actions and judgments allegedly made by United about whether the Plan should authorize payment for Petitioner's hospitalization. As the Fifth Circuit correctly held, "The existence of a true doctor-patient relationship between Mrs. Corcoran and United . . . is dubious at best." 965 F.2d at 1337, Pet. App. at A-35. "United makes medical decisions as part and parcel of its mandate to decide what benefits are

available under the . . . plan." 965 F.2d at 1332, Pet. App. at A-24.

B. COURSE OF PROCEEDINGS AND DISPOSITION OF CASE BELOW

Petitioners filed suit on October 8, 1990, in the 22nd Judicial District Court for the Parish of St. Tammany, State of Louisiana, alleging United and Blue Cross negligently deprived Ms. Corcoran of medical care or hospitalization, and improperly provided inadequate medical oversight and incomplete medical information in connection with Petitioner's claim for benefits.

The Respondents removed the action to the United States District Court for the Eastern District of Louisiana on October 30, 1990, under 28 U.S.C. § 1331, because the claims arise under and are preempted by ERISA, and the district courts have jurisdiction over ERISA actions pursuant to Section 502(e)(1) of ERISA, 29 U.S.C. § 1132(e)(1).[7]

The District Court on March 8, 1991, granted Respondents' Motion for Summary Judgment. The District Court held ERISA preempted Petitioners' state law claims because the ERISA plan was the source of the relationship between the Corcorans and defendants, and thus the claims related to the plan:

> Here, the existence of the ERISA plan "is a critical factor in establishing liability under" the plaintiffs' would-be state-law malpractice claim. *Cf. Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 483. . . .
>
> Without the ERISA plan, the plaintiffs could not establish – as an issue of fact – that the

---

[7] Another basis for removal was complete diversity among Plaintiffs and Defendants, 28 U.S.C. § 1332.

> defendants breached any duty to them, for the source of the defendants' obligations arose from the ERISA plan itself . . . .

Pet. App. at A-44 to A-45.[8] The District Court on April 4, 1991 denied Petitioners' Motion for Reconsideration, declining to deviate from the majority rule that "a beneficiary under an ERISA health plan may not recover under section 509(a)(3) [sic] of ERISA compensatory or consequential damages for emotional distress or other claims beyond medical expenses covered by the plan." Pet. App. at A-49.[9] The District Court held this case did not implicate the concern over lack of a remedy because the plaintiffs did have a remedy when informed that hospital care would not be covered. The District Court also rejected Petitioners' position because under the language of § 502(a)(3), absent a violation of the terms of ERISA, there could be no claim for damages, and "plaintiffs can show no duty that the defendants allegedly breached under ERISA." The District Court held as a matter of law that the Plan documents unambiguously refuted any claim that United acted as Petitioner's physician. Pet. App. at A-50.

The Fifth Circuit affirmed the District Court's grant of summary judgment to Respondents. The Fifth Circuit held that the Corcorans' claims were preempted, because any actions by United were performed in its role as an ERISA plan administrator:

> Ultimately, we conclude that United makes medical decisions – indeed, United gives medical advice – but it does so in the context of

---

[8] Respondents disagree with Petitioner's statement that the District Court reached a decision "[w]ithout actually analyzing the nature and source of the Corcorans' claim." Pet. Brief at 6.

[9] The relevant ERISA provisions are set forth in Petitioners' Appendix, at A-51 to A-53.

> making a determination about the availability of benefits under the plan.
>
> * * * *
>
> . . . The principle of *Pilot Life* that ERISA pre-empts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here.

965 F.2d at 1331, 1332, Pet. App. at A-21, A-24.[10] The Fifth Circuit also explicitly held "the lack of an ERISA remedy does not affect a pre-emption analysis." 965 F.2d at 1333, Pet. App. at A-27.

With respect to the claim for extracontractual damages under § 502(a)(3), the Fifth Circuit expressly pretermitted the issues of whether Plaintiffs had stated a claim under the provision, and whether the provision permits the recovery of extracontractual damages within the meaning of "other equitable relief." Instead, the Fifth Circuit resolved the claim for damages by concluding that *even if* the Corcorans had stated a claim and *even if* such damages were within the statutory meaning of "equitable relief," the Petitioners would not be entitled to damages under the circumstances of this case, based on principles of trust and contract law. "The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best," 965 F.2d at 1337, Pet. App. at A-35, and "the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines . . . recovery" on the basis of a breach of a fiduciary relationship, 965 F.2d at 1338, Pet. App. at A-36.

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[10] Petitioner is incorrect that "the Fifth Circuit agreed with the Corcorans' position that United HealthCare made medical decisions . . . " Pet. Brief at 7. The Fifth Circuit stated expressly that it "cannot fully agree with either United or the Corcorans." 965 F.2d at 1331, Pet. App. at A-21.

SUMMARY OF THE ARGUMENT

Petitioner has failed to show any special or important reasons this Court should grant her Petition.

The holdings of the District Court and the Fifth Circuit Court of Appeals were correct as a matter of law. ERISA contains an explicit, broad preemption clause, under which Petitioner's claims were correctly held preempted, and a comprehensive civil enforcement scheme which was correctly held not to provide the type of remedies sought by Petitioners in this case.

Furthermore, Petitioner has failed to present any decisions of this Court or any other circuit court of appeals which conflict with the decision below regarding preemption; the one case presented is clearly distinguishable on its facts and law. With respect to damages, the Fifth Circuit correctly decided Petitioners were not entitled to emotional distress or mental anguish damages under ERISA. However, the Fifth Circuit expressly did not decide whether ERISA generally provides extracontractual remedies; thus, this is an issue not appropriate for review in this case. Although the Fifth Circuit expressly pretermitted the issues of whether ERISA generally provides extracontractual relief, or whether Petitioners had stated a cause of action for damages, authority in a majority of circuits provides an independent ground for affirming the result reached.

ARGUMENT

REASONS FOR DENYING THE PETITION

A. THE DECISION BELOW WAS CORRECT

The Court of Appeals' two holdings in the instant case are legally correct, and consistent with prior decisions

of this Court and those of other circuit courts. Thus, no review is needed or required.

The Court of Appeals held ERISA preempts the Petitioner's claims because even though the Court concluded United makes medical decisions, "it does so in the context of making a determination about the availability of benefits under the plan." 965 F.2d at 1331, Pet. App. at A-21. As the court correctly stated,

> Congress perhaps could not have predicted the interjection into the ERISA "system" of the medical utilization review process, but it enacted a pre-emption clause so broad and a statute so comprehensive that it would be incompatible with the language, structure and purpose of the statute to allow tort suits against entities so integrally connected with a plan.

965 F.2d at 1334, Pet. App. at A-27. The Court of Appeals properly applied the explicit and expansive ERISA preemption clause, in accord with Congressional intent and clear precedent.

Even assuming that the Corcorans state a claim for relief under § 502(a)(3)(B), and that extracontractual damages are an available remedy thereunder, the Fifth Circuit correctly decided that the facts of the instant case did not entitle the Corcorans to money damages under well-established trust and contract law principles because Petitioner seeks "make-whole" damages which cannot be available absent a "true doctor-patient relationship."[11]

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[11] The damages sought also should be unavailable because they do not constitute "other appropriate equitable relief." *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1463 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884 *and* 479 U.S. 1089, 107 S.Ct. 1298 (1987). Equitable relief consists of remedies such as rescission,

Further, the six carefully integrated civil enforcement provisions demonstrate that Congress did not intend to authorize any remedies under ERISA other than those expressly set forth in the statute. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 146, 105 S.Ct. 3085, 3092 (1985). This Court was "reluctant to tamper with an enforcement scheme crafted with such evident care as the one in ERISA." *Russell*, 473 U.S. at 147, 105 S.Ct. at 3093.

B. THE PETITION DOES NOT PRESENT ANY OF THE REQUISITE FACTORS CONSIDERED BY THIS COURT IN GRANTING A PETITION FOR WRIT

1. There is no conflict in the circuits over whether professional malpractice actions such as this one are preempted by 29 USC § 1144(a).

a. The allegedly conflicting case is distinguishable on its facts and law.

Appellants cite only one circuit court case, *Painters of Philadelphia Dist. Council No. 21 Welfare Fund v. Price Waterhouse*, 879 F.2d 1146 (3d Cir. 1989), which purportedly conflicts with the decision of the Fifth Circuit in this

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removal of a trustee or appointment of a receiver. *Id.* Like punitive damages, compensatory damages are not "equitable relief," but are legal in nature. *Chauffeurs, Teamsters and Helpers, Local No. 391 v. Terry*, 494 U.S. 558, 110 S.Ct. 1339, 1347-48 (1990). The Supreme Court noted in *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 105 S.Ct. 3085 (1985), that originally the civil enforcement provision provided for "the full range of *legal* and equitable remedies available in both state and federal courts." 473 U.S. at 146, 105 S.Ct. at 3092. In the bill ultimately adopted, however, the reference to legal remedies was omitted, indicating an affirmative choice by Congress to eliminate those remedies. *Id.*

case. *Painters* is distinguishable on its law and facts, and thus does not present a conflict.

In *Painters*, an employee welfare fund and its trustees sued the fund's former auditor under ERISA, alleging the auditors had a fiduciary duty to the plan to conduct audits in accordance with generally accepted accounting principles, and had breached this duty by failing adequately to investigate and evaluate fees and expenses charged by the plan administrator. The Third Circuit affirmed the district court's dismissal for failure to state an ERISA claim because (1) the auditor was not a fiduciary, and (2) ERISA provided no express or implied cause of action against a non-fiduciary under the circumstances of that case.

Factually, the case is completely dissimilar from the claim *sub judice*. In *Painters*, a plan and its trustees sued an entity it had retained to perform services. The relationship which formed the basis of the dispute was not one intended to be regulated by ERISA. The legal posture of the case differs because it was brought in Federal court by the fund under ERISA, and the issue was whether ERISA provided a cause of action.[12]

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[12] The district court cases cited by Petitioner to show a conflict among circuits are also distinguishable. *Pickett v. Cigna Healthplan of Texas, Inc.*, 742 F.Supp. 946 (S.D. Tex. 1990), was a suit against Cigna as operator of a health maintenance organization, acting independently from its capacity as plan administrator, in contrast to United, which was acting pursuant to its authority and responsibility under the Plan. *Independence HMO, Inc. v. Smith*, 733 F.Supp. 983 (E.D.Pa. 1990) was correctly held by the Fifth Circuit to be distinguishable on its facts because "the medical decisions at issue do not appear to have been made in connection with a cost containment feature of the plan or any other aspect of the plan which implicated the management of

b. The preemption discussion is dictum and thus does not constitute a conflicting decision

Preemption was not a determinative factor in *Painters;* the court did not need to address preemption at all to reach a decision on whether ERISA provided a cause of action. Thus, the Third Circuit's footnote discussion of preemption, 879 F.2d at 1153 n.7, is merely dictum, and Petitioner's presentation of this discussion as evidence of a conflict among circuits is incorrect.[13]

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plan assets, but were instead made by a doctor in the course of treatment." 965 F.2d at 1333 n. 16, Pet. App. at A-26 n.16.

[13] This is obscured by Petitioners' failure to distinguish between the preemption analysis in this footnote and the implied cause of action analysis in the body of the *Painters* opinion. Following their reference to the *Painters* preemption discussion, Petitioners write,

> The court premised *its conclusion* upon the facts that 1) professional malpractice liability was a matter of traditional state regulations, and 2) there was no explicit provision in ERISA to permit such actions under its provision *if state law were preempted.*

Pet. Brief at 12 (emphasis added). This suggests the *Painters* court premised its *preemption* conclusion on the listed factors, but the opinion does not support this. The court in its footnote does not discuss any relationship between preemption and whether or not professional liability is traditionally a matter of state law. Rather, the court's conclusion *that no cause of action should be implied,* following the *Cort v. Ash,* 422 U.S. 66, 95 S.Ct. 2080, 45 L.Ed.2d 26 (1975), four-factor analysis, was based, *inter alia,* on the fact that professional liability was traditionally a matter of state law. 879 F.2d at 1152-1153. Furthermore, the *Painters* court nowhere suggests that its *Cort* analysis depends on a preemption determination.

c. Even assuming the footnote preemption discussion constitutes a "decision," it is not a conflicting decision.

Even assuming, *arguendo*, that the footnote discussion of preemption is an adjudication of the matter, the Fifth Circuit's decision below and *Painters* are reconcilable and do not establish a conflict among circuits.

The court in *Painters* relied on this Court's decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 108 S.Ct. 2182 (1988) in concluding that professional malpractice actions *in general* were not preempted by ERISA. *Mackey*, and the cases it cited in dictum in the paragraph referenced by Petitioner, not only do not conflict with but in fact support the Fifth Circuit decision below.

The court in *Painters* concluded only that "ERISA does not generally preempt state professional malpractice claims." 879 F.2d at 1153 n.7. Such a holding does not conflict with the Fifth Circuit decision below, which held *specifically* that a state "tort action . . . for . . . wrongful death allegedly resulting from United's erroneous medical decision is preempted by ERISA." 965 F.2d at 1331, Pet. App. at A-21. As the Fifth Circuit explained, a "tort allegedly committed in the course of handling a benefit determination" is preempted under *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 107 S.Ct. 1549 (1987). 965 F.2d at 1332, Pet. App. at A-24.

This Court in *Mackey* reconciled precisely that type of distinction between the general and the specific. In *Mackey*, the Supreme Court held a specific anti-garnishment statute directed to ERISA plans was preempted, while the generally applicable state garnishment statute was not. Analogously, the Fifth Circuit below held that a specific cause of action relating to an ERISA plan benefits

determination was preempted, while *Painters* held that professional liability law *generally* was not preempted.

A recent District Court decision squarely shows why *Painters* is distinguishable from and reconcilable with the decision below. In *Elsesser v. Hospital of Philadelphia College of Osteopathic Medicine, Parkview Div.*, 1992 U.S. Dist. LEXIS 16046 (E.D.Pa. 1992) (set forth in Appendix A), the District Court, relying on *Painters* and the Fifth Circuit decision below, held ERISA did not preempt a state law claim of medical malpractice, but did preempt state law claims of negligent failure to provide coverage, misrepresentation, and breach of contract. The plaintiffs sought to hold the defendant HMO vicariously liable for the allegedly negligent medical decisions of plaintiff's treating physician. The court held ERISA did not preempt these medical malpractice claims because "the allegations . . . do not rely on obligations under U.S. Health Care's benefits plan, but on the principles of professional malpractice," citing *Painters*. However, citing the Fifth Circuit decision below, the court held ERISA preempted all of plaintiff's remaining claims, including claims that the HMO negligently refused to pay for certain care, misrepresented the quality of care, and breached a contract to provide quality care, because all these claims clearly had "a connection with or reference to a benefit plan."

The distinction made by the *Elsesser* District Court between allegations of negligent medical treatment and allegations relating to the ERISA benefit plan establishes that the Fifth Circuit decision below was correct and not in conflict with *Painters*. In the instant case, Petitioner did not allege, and could not have alleged, an analogous "pure" medical malpractice claim against United, because United was not a physician who provided medical care to Petitioner. As the Fifth Circuit correctly concluded, "[t]he existence of a true doctor-patient relationship between Mrs. Corcoran and United . . . is dubious at best." 965

F.2d at 1337, Pet. App. at A-35. Because the only purportedly medical decisions at issue were made in connection with a benefit determination, any claim related thereto must be preempted, as the Fifth Circuit correctly held. Moreover, the *Elsesser* court properly interpreted the *Painters* preemption discussion as relating only to a true medical malpractice claim. The claim for failure to provide benefits, which is analogous to the instant case, was correctly held preempted; obviously the *Elsesser* court did not construe *Painters* as requiring a different result.

2. The Fifth Circuit Decision Does Not Conflict With Any Supreme Court Decision Construing 29 USC § 1144(a) Or The Legislative Purpose Embodied In ERISA.

a. The Fifth Circuit decision does not conflict with this Court's decision in *Mackey*.

Contrary to Petitioner's assertion, the Fifth Circuit decision below does not conflict with any Supreme Court decision. The case cited by Petitioner to support his claim of conflict, *Mackey*, has already been held *by this Court* to be distinguishable from and therefore consistent with the ERISA preemption Supreme Court decisions on which the Fifth Circuit relied.

In *Mackey*, this Court affirmed a Georgia Supreme Court decision that a state statute barring garnishment of ERISA welfare plan benefits was preempted, while the general state garnishment law was not preempted. This Court held the anti-garnishment statute's "express reference to ERISA plans suffices to bring it within the federal law's preemptive reach," 486 U.S. at 830, 108 S.Ct. at 2186. With respect to the general garnishment statute, however, this Court relied on ERISA provisions and the statute's structure to conclude Congress did not intend to

forbid state garnishment procedures against welfare plans. 486 U.S. at 831, 108 S.Ct. at 2186.

In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 111 S.Ct. 478 (1990), this Court held ERISA preempted a state common law claim of wrongful discharge to prevent attainment of ERISA pension benefits. The Court noted that although it had recognized certain limits to ERISA preemption, citing *Mackey* and *Ft. Halifax Packing Co. v. Coyne*[14], these limitations were not applicable in the case before it:

> We are not dealing here with a generally applicable statute that makes no reference to, or indeed functions irrespective of, the existence of an ERISA plan. Nor is the cost of defending this lawsuit a mere administrative burden. Here, the existence of a pension plan is a critical factor in establishing liability under the State's wrongful discharge law. As a result, this cause of action relates not merely to pension benefits, but to the essence of the pension plan itself.

498 U.S. at ___, 111 S.Ct. at 483.

The limitation on preemption recognized in *Mackey* is not applicable in the case *sub judice* because, as the Fifth Circuit correctly held, "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan." 965 F.2d at 1334, Pet. App. at A-29. As in *Ingersoll-Rand*, the court's inquiry in this case must be directed to the plan, because the action which forms the basis of the cause of action, "a tort allegedly committed in the course of handling a benefit

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[14] 482 U.S. 1, 23, 107 S.Ct. 2211, 2223-24 (1987) (holding that a state law which required payment of severance benefits was not preempted because the statute did not require the establishment or maintenance of an ongoing plan).

determination," 965 F.2d at 1332, Pet. App. at A-24, would not have occurred had there been no plan.

Petitioner cites the dicta in *Mackey* listing "run-of-the-mill" state law claims that the parties conceded were not preempted, including claims against plans for unpaid rent, for unpaid attorneys' fees, and for libel. 486 U.S. at 833 n.8, 108 S.Ct. at 2187 n.8. None of these state law cases is analogous here because they were totally unrelated to the performance by the defendant plan of any ERISA functions. Petitioner's characterization of the instant claim as within the "run of the mill tort claim" category is simply without any support in the *Mackey* decision. Nor would the Fifth Circuit agree with this characterization. The Fifth Circuit referenced the *Mackey* list of "run of the mill" state claims, 965 F.2d at 1329, Pet. App. at A-17, but nevertheless concluded the case was outside this category because it involved:

> . . . a tort allegedly committed in the course of handling a benefit determination . . . . The principle of *Pilot Life* that ERISA preempts state-law claims alleging improper handling of benefit claims is broad enough to cover the cause of action asserted here . . . . [T]he central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan.

965 F.2d at 1332, 1334, Pet. App. at A-24, A-29.

A cause of action for medical negligence in connection with a benefit determination is neither a "run of the mill" state law claim, *Mackey*, 108 S.Ct. at 2187, nor a "generally applicable" cause of action that "functions irrespective of the existence of an ERISA plan." *Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 483. Thus, the Fifth Circuit's conclusion that such a cause of action is preempted by ERISA does not conflict with *Mackey*.

b. The Fifth Circuit decision does not conflict with the legislative purpose of ERISA

Petitioner argues that preemption in this case is inconsistent with the purposes of ERISA because ERISA was adopted to protect "worker's [sic] rights," Pet. Brief at 18, and a state law which presumably also protects individuals by providing a remedy for "wrongful death due to medical negligence," Pet. Brief at 17, should not be preempted.[15]

Petitioner's argument is premised on the incorrect presumption that the purposes of ERISA and the state law governing medical negligence are the same. The legislative history of ERISA does not support this. As Petitioner correctly states, Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefits plan," Pet. Brief at 15. There is no support for an assertion that the state law of medical malpractice has the same purpose. It is an illogical leap to say that both "laws" have the same purpose because they both protect "worker's rights" [sic]. Carrying this argument to the extreme, under Petitioner's reasoning it would be inappropriate for any state law which gives remedies to individuals to be preempted by any Federal law with a similar effect.[16]

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[15] Although this argument goes to the merits of the Fifth Circuit decision and "conflict with legislative purpose" is not one of the enumerated reasons for a grant of certiorari under Sup.Ct.R. 10.1, Respondents address the argument to assure complete presentation of its position, and to point out errors in Petitioner's discussion of the law.

[16] Also flawed is Petitioner's conclusory statement that the remedy sought here is one "previously available under state law

Petitioner's argument also is premised on an incorrect representation of the opinion below. The Fifth Circuit specifically held that ERISA preempts the tort action because it was "allegedly committed in the course of handling a benefit determination," and because "the central purpose of the lawsuit is to hold United liable for actions it took in connection with its duties under the plan." 965 F.2d at 1332, 1334, Pet. App. at A-24, A-29. Petitioner's assertions that this claim is a "run of the mill tort claim for medical malpractice" and that Congress could not have "intended to deprive them of all remedies for wrongful death due to medical negligence" are misleading because they ignore this essential aspect of the Fifth Circuit decision.[17]

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prior to ERISA's enactment." Pet. Brief at 17. Although Louisiana law provides the remedy of money damages for wrongful death, *Danos v. St.Pierre*, 402 So.2d 633 (La.1981), it is incorrect that Louisiana necessarily provides a remedy for "medical malpractice committed in connection with a plan benefit determination," 965 F.2d at 1333, Pet. App. at A-26. Rather, this is a matter for which there is a "lack of clear Louisiana authority." 965 F.2d at 1328, Pet. App. at A-14.

[17] Furthermore, even assuming *arguendo* that the state and Federal laws at issue in this case have the same purpose, this Court has consistently rejected the argument that only state laws which conflict with federal laws should be preempted. *See Morales v. Trans World Airlines, Inc.*, ___ U.S. ___, 112 S.Ct. 2031, 2038 (1992) (relying on ERISA cases in rejecting the argument that preemption is inappropriate when state and federal law are substantively consistent, citing *Mackey*, 486 U.S. at 829, 108 S.Ct. at 2185, and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739, 105 S.Ct. 2380, 2388-2389 (1985)). Thus, even assuming there is a substantive link between a Federal law's purpose of protecting plan participants with respect to plan benefits, and a state law's purpose of providing a remedy for wrongful death, such an absence of conflict does not change the preemption analysis.

As an example of a case in which this Court held a state law not preempted because a preemption conclusion would conflict with Congressional intent, Petitioner cites *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 104 S.Ct. 615 (1984). This Court held in *Silkwood* that a punitive damages award for personal injuries suffered in a radiation accident was not preempted by the Federal law regulating safety of nuclear power plants. However, this Court in *Silkwood* expressly based its conclusion on explicit legislative history showing Congressional intent to allow state law tort remedies for personal injuries in connection with radiation accidents. 464 U.S. at 249-256, 104 S.Ct. at 622-626.

There is no analogous legislative history to support Petitioner's argument. As the Fifth Circuit noted, ERISA has an explicit, broad preemption clause with "deliberately expansive" language, "consistent with Congress's decision to create a comprehensive, uniform federal scheme for the regulation of employee benefit plans." 965 F.2d at 1328-1328, Pet. App. at A-15 to A-16.[18] To support the analogy to *Silkwood*, Petitioner would have to produce legislative history showing Congress intended to preserve state-law remedies for injuries resulting from failure of plans to comply with ERISA. Petitioner cannot

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[18] Because ERISA has an express broad preemption clause, Petitioner's citation of the reference in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985), to a presumption against preemption of areas of traditional state regulation is not persuasive. As the Fifth Circuit correctly held, "As cases such as *Ingersoll-Rand* . . . (other citations omitted) illustrate, the fact that states traditionally have regulated in a particular area has functioned as no impediment to *ERISA* pre-emption." 965 F.2d at 1334, Pet. App. at A-27 to A-28. (Emphasis added.)

make such an argument in the face of ERISA's comprehensive civil enforcement scheme.

That Petitioner seeks money damages unavailable under ERISA for "a tort allegedly committed in the course of handling a benefit determination," 965 F.2d 1332, Pet. App. at A-24, does not change the ERISA preemption analysis. As the Fifth Circuit correctly noted,

> The acknowledged absence of a remedy under ERISA's civil enforcement scheme for medical malpractice committed in connection with a plan benefit determination does not alter our conclusion. While we are not unmindful of the fact that our interpretation of the preemption clause leaves a gap in remedies within a statute intended to protect participants in employee benefit plans [citations omitted] . . . , *the lack of an ERISA remedy does not affect a pre-emption analysis.*

965 F.2d at 1333. Pet. App. at A-26 to A-27 (emphasis added).[19] *Cf. Caterpillar, Inc. v. Williams*, 482 U.S. 386, 391 n.4, 107 S.Ct. 2425, 2429 n.4 (1987) (rejecting Court of Appeals reasoning that case may not be removed to Federal court on preemption grounds unless Federal cause of action provides plaintiff with a remedy).[20]

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[19] As the District Court correctly noted, Petitioner had remedies available to her under ERISA for the denial of benefits, remedies that she did not exercise. She could have appealed the decision under the Plan appeal procedures, sued for a declaratory judgment regarding coverage on an expedited basis, or pursued the treatment recommended by her physician and sued under ERISA for coverage of her expenses. (Appellants' Rec. Exc. pp. 40-41).

[20] *See also Pohl v. National Ben. Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992), which held ERISA preempted a state law claim against a plan administrator seeking damages sustained as a

Congress intended in enacting ERISA that "plans and plan sponsors would be subject to a uniform body of benefit law" and not subject to the "burdens of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at ___, 111 S.Ct. at 484. The Fifth Circuit furthers this purpose by avoiding a decision that could lead "to the kind of patchwork scheme of regulation Congress sought to avoid." 965 F.2d at 1333, Pet. App. at A-25.

3. The Decision Of The Fifth Circuit Below Does Not Conflict With Decisions In Other Circuits Or Present An Unsettled Question Of Law Regarding Whether Extracontractual Damages Are Recoverable Under ERISA § 502(a)(3)(B), Because This Question Was Not Decided By The Fifth Circuit.

The Fifth Circuit in this case expressly pretermitted the issue of whether ERISA Section 502(a)(3)(B) permits the recovery of extracontractual damages, resolving the claim for damages instead by concluding that *even if* Petitioners had stated a claim under the provision, and *even if* such damages were an available remedy, the Petitioners would not be entitled to damages under the circumstances of this case:

> Assuming *without deciding*, therefore, that § 502(a)(3) permits the award of make-whole

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result of misrepresentation as to plan coverage:

> The fact that ERISA does not provide a substitute remedy reflects not a senseless gap in the statute but a determination to carry through the policy we have described by confining participants to the entitlements spelled out in writing. Not the semantics of the word "relate," but the policy of the statute, requires preemption and the denial of a remedy.

956 F.2d at 128.

> relief as 'other appropriate equitable relief,' we hold that the emotional distress and mental anguish damages sought here by the Corcorans are not recoverable.

(Emphasis added.) 965 F.2d at 1338, Pet. App. at A-36. Petitioner acknowledges that the Fifth Circuit did not decide this question. Pet. Brief at 19.

Whether or not there is a conflict in the circuits over this question thus is not relevant to the instant Petition. Even assuming that there is a conflict among circuits, and that the question is unsettled and of sufficient importance to warrant resolution by this Court, *this case* does not provide a basis for granting certiorari to resolve the question because the Fifth Circuit neither "rendered a decision" nor "decided an important question," Sup. Ct. R. 10, with respect to this ERISA provision. Thus, the issue would not be properly before this Court if certiorari were granted. Even if the issue is sufficiently important to justify resolution by this Court, it should be settled upon review of a case which decided this particular issue.

C. THE DECISION OF THE FIFTH CIRCUIT ALSO MAY BE AFFIRMED ON OTHER GROUNDS

Notwithstanding the Fifth Circuit's pretermission of this issue, the result reached was correct and may be affirmed on the following independent grounds.

1. ERISA Does Not Permit Recovery Of Extracontractual Or Compensatory Damages

Petitioner argues that if her state law claims are preempted by ERISA, she nonetheless has a cause of action under ERISA for compensatory extracontractual damages under 29 U.S.C. § 1132(a). Petitioner characterizes her claim as one arising under § 1132(a)(3). Petitioner's complaint, however, concerns actions which

United took in its capacity as a fiduciary of the Plan. Therefore, Petitioner's claims are more properly characterized as claims under § 1132(a)(2).[21]

The Supreme Court has held that extracontractual compensatory and punitive damages are not available under § 1109 and § 1132(a)(2). *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148, 105 S.Ct. 3085, 3093 (1985). Thus, Petitioner's claims for extracontractual damages are foreclosed. However, even if Petitioner's claims can be brought under § 1132(a)(3), virtually every court of appeals which has considered the issue has held that compensatory, punitive and other extracontractual damages are not available under § 1132(a) of ERISA.[22]

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[21] Section 1132(a)(2) allows a civil action to be brought for appropriate relief under the provision relating to breach of fiduciary duty, 29 U.S.C. § 1109.

[22] *See Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enterprises, Inc.*, 793 F.2d 1456, 1463-1464 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034, 107 S.Ct. 884 *and* 479 U.S. 1089, 107 S.Ct. 1298 (1987); *Drinkwater v. Metropolitan Life Ins. Co.*, 846 F.2d 821, 825 (1st Cir. 1988), *cert. denied*, 488 U.S. 909, 109 S.Ct. 261 (1988); *Powell v. Chesapeake & Potomac Tel. Co.*, 780 F.2d 419, 424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170, 106 S.Ct. 2892 (1986); *Reinking v. Philadelphia American Life Ins. Co.*, 910 F.2d 1210, 1219-20 (4th Cir. 1990); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987); *Kleinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 625-27 (7th Cir. 1987); *Hancock v. Montgomery Ward Long Term Disability Trust*, 787 F.2d 1302, 1306-07 (9th Cir. 1986); *Forys v. United Food & Commercial Worker's Int'l Union*, 829 F.2d 603, 604-05 n.2 (7th Cir. 1987); *Dependahl v. Falstaff Brewing Corp.*, 653 F.2d 1208, 1216 (8th Cir.), *cert. denied* 454 U.S. 968, 102 S.Ct. 512 *and* 454 U.S. 1084, 102 S.Ct. 641 (1981); *Sokol v. Bernstein*, 803 F.2d 532, 534-37 (9th Cir. 1986); *McRae v. Seafarer's Welfare Plan*, 920 F.2d 819, 821-23, *reh'g denied (en banc)*, 931 F.2d 901 (11th Cir. 1991); *c.f. Morales v. Pan American Life Ins. Co.*, 914 F.2d 83, 87 (5th Cir. 1990).

Petitioner's reliance on the case of *Warren v. Society Nat. Bank*, 905 F.2d 975, 982 (6th Cir. 1990), *cert. denied*, 111 S.Ct. 2256 (1991) is misplaced. Even in *Warren*, the Sixth Circuit held that, although compensatory damages may be appropriate in certain circumstances, extracontractual damages for *emotional distress* are excluded *per se* from "other appropriate equitable relief" under § 1132(a)(3). *Boland v. Chrysler Corp.*, 933 F.2d 1007 (table), 13 E.B.C. 2456, 2458 (6th Cir. 1991), *citing Warren*, 905 F.2d at 980, 983. *Warren* held that "clearly consequential damages" such as claims for emotional distress were not recoverable. *Id.* at 983.

Petitioner cites *Ingersoll-Rand*, as having "clearly suggested" that extracontractual money damages are recoverable under § 502(a)(3)(B). In *Ingersoll-Rand*, this Court held a state law claim for wrongful discharge to prevent attainment of ERISA pension benefits was preempted under ERISA's express preemption clause, and, alternatively, because the claim conflicted directly with Section 510 of ERISA, which makes it unlawful to discharge a plan participant for the purpose of interfering with the attainment of a right to benefits. In discussing this latter "conflict pre-emption," the Court stated that because § 502(a) provides the exclusive remedy for vindicating § 510-protected rights, an appropriate remedy must be available under § 502(a). 498 U.S. at ___, 111 S.Ct. at 486. To support an analogy to the instant case, Petitioners would have to point to a violation of an ERISA provision. Because they cannot do so, the analogy must fail.

The legislative history of ERISA also gives no support to a congressional intent to provide extracontractual damages of any kind. While Congress repeatedly emphasized the purpose of protecting contractually defined benefits, nowhere did the legislative history indicate an

intent to provide extracontractual damages. Indeed, Congress was concerned that the high costs of benefit plans would discourage employers from offering them. *Russell*, 473 U.S. at 148 & n.17, 105 S.Ct. at 3093 & n.17 (and legislative history cited therein). This concern about costs arises regardless of whether a participant seeks such damages under § 1109 or § 1132(a)(3).

Despite Petitioner's argument to the contrary, the same rationale for rejecting extracontractual damages under § 1109 applies in determining whether such damages are available under 29 U.S.C. § 1132(a)(3)(B). The logic of *Russell* "forecloses the availability of extra-contractual damages under § 502(a)(3) [§ 1132(a)(3)]." *Sokol v. Bernstein*, 803 F.2d 532, 536 (9th Cir. 1986). The legislative history of ERISA clearly indicates that "other appropriate equitable relief" means just that – injunctive or declaratory relief, such as removal of the trustee. *Id.* at 537 (and the legislative history cited therein). The *Sokol* court expressly rejected extracontractual claims for damages for emotional distress. *Id.* at 538.

In enacting the civil enforcement provisions of ERISA, Congress was balancing the interests of participants in protecting their accrued benefits and the need to encourage employers to provide benefit plans:

> Under the civil enforcement provision of § 502(a), a plan participant or beneficiary may sue to recover damages due under the plan, *to enforce the participant's rights under the plan, or to clarify rights to future benefits.* Relief may take the form of accrued benefits due, *a declaratory judgment on entitlement to benefits, or an injunction against a plan administrator's improper refusal to pay benefits.*

Pilot Life, 481 U.S. at 53, 107 S.Ct. at 1556 (emphasis added). If the participant is forced to seek these remedies, the court has the discretion to award attorneys fees under

29 U.S.C. § 1132(g). *Id.* Thus, Petitioner's rights as a participant were fully protected by ERISA.

Any concern about the breadth of ERISA preemption and the narrowness of the civil enforcement provisions must be addressed to Congress, not this court. *See Russell*, 473 U.S. at 145; 105 S.Ct. at 3092.

2. Even If Compensatory Or Other Extra-contractual Damages Were Available Under ERISA, Plaintiff Has No Claim Under ERISA, Because Defendants Did Not Breach Any ERISA Fiduciary Duties To Plaintiff

Even if compensatory or other extracontractual damages were available, Petitioner had no claim under ERISA because Respondents breached no ERISA fiduciary duties. The facts alleged in Petitioner's complaint all concern an alleged physician-patient relationship between United and Petitioner or assume that United had a duty to Plaintiff to make recommendations regarding her treatment.

The District Court, upon reviewing the plan documents, determined that the only relationship between the parties was that of plan administrator and participant, as made clear by the SPD and Explanatory Booklet:

> [T]he ERISA plan here concerned only the payment, not the medical propriety, of health-care expenses and expressly provided that no such doctor-patient relationship was created by the plan: the plan contained specific warnings that all health care decisions were for the plan participant and her treating doctor to make.

(Appellants' Rec. Exc. p. 41). Respondents had no duty under ERISA to determine what type of treatment was appropriate for Petitioner. Rather, Respondents made coverage determinations.

The Fifth Circuit also concluded correctly, "The existence of a true doctor-patient relationship between Mrs. Corcoran and United which could support a contractual theory of recovery is dubious at best." 965 F.2d at 1337, Pet. App. at A-35, and "the lack of a true doctor-patient relationship between Mrs. Corcoran and United undermines . . . recovery" on the basis of a breach of a fiduciary relationship, 965 F.2d at 1338, Pet. App. at A-36.

Petitioner has not argued that Respondents wrongfully failed to perform their duties under the Plan.[23] Therefore, Petitioner has no claim under ERISA.

CONCLUSION

It is respectfully submitted that petitioner has wholly failed to sustain its burden of establishing under Sup.Ct.R.10 that there are special and important reasons the writ should be granted. The decision below does not conflict with applicable decisions of this Court or of another Court of Appeals on the same matters; nor has the Court of Appeals decided an important federal question which has not been, but should be, settled by this court at this time. The Fifth Circuit Court of Appeals correctly decided that Petitioner's claims are preempted, and that Petitioner is not entitled to extracontractual

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[23] Petitioner admits she has been paid all benefits due and owing to her under the Plan relating to the pregnancy. (*See* Appellees' Rec. Exc., pp. 37-38.)

damages under the circumstances of this case. Therefore, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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APPENDIX A

VIRGINIA ELSESSER and COURAGE VERZICCO, co-guardians of the Estate and Person of CAROLYN VERZICCO, an incompetent

VS.

HOSPITAL OF THE PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE, PARKVIEW DIVISION, a Pennsylvania Corporation, et al

C.A. NO. 92-3045

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

1992 U.S. Dist. LEXIS 16046

September 30, 1992, Decided
September 30, 1992, Filed

COUNSEL: [*1]

For VIRGINIA ELSESSER, COURAGE VERZICCO, Co-Guardians of the Estate and Person of Carolyn Verzicco, an incompetent, PLAINTIFFS: GARY M. GUSOFF, 2401 WALNUT ST., SUITE 102, PHILA., PA 19103.

For U.S. HEALTHCARE, INC., DEFENDANT: GILBERT F. CASELLAS, KIMBERLY H. HUMES, MONTGOMERY, MC CRACKEN, WALKER & RHOADS, THREE PARKWAY, 20TH FL., PHILA, PA 19102, USA.

JUDGES: WEINER

OPINIONBY [sic]: CHARLES R. WEINER

OPINION: MEMORANDUM OPINION AND ORDER

WEINER, J.

SEPTEMBER 30, 1992

Plaintiffs originally brought this personal injury action in the Court of Common Pleas of Philadelphia

County against a hospital, several doctors in the emergency room of the hospital, plaintiffs' incompetent's primary care physician, and United States Health Care Systems of Pennsylvania, Inc. ("U.S. Health Care"), a health maintenance organization ("HMO"). U.S. Health Care subsequently removed the action to this court pursuant to 28 U.S.C. @ 1441(b), claiming that the causes of action plaintiffs assert against it arise under the laws of the United States. The suit arises out of personal injuries allegedly sustained by plaintiffs' incompetent Carolyn Verzicco ("Verzicco") as a result of care she received at the hospital [*2] of the Philadelphia college of Osteopathic Medicine, Parkview Division ("Parkview") in connection with U.S. Health Care's selection of primary care physicians. U.S. Health Care filed a motion to dismiss the Complaint against it for failure to state a claim upon which relief can be granted pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. In its motion, U.S. Health Care argued that plaintiffs' state law claims asserted against it should be dismissed as pre-empted by the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. @ 1001 et seq. Plaintiffs responded by filing a motion to remand the entire action to the state court on the basis that the state claims are not preempted by ERISA. By Memorandum Opinion and Order dated July 13, 1992, we denied the motion to dismiss and granted the motion to remand. Presently before the court is the motion of U.S. Health Care for reconsideration n1 or, in the alternative, for certification for immediate appeal under 28 U.S.C. Section 1292(B). For the reasons which follow, the motion for reconsideration is granted in part and denied in part and the motion for certification [*3] is denied.

----------Footnotes----------

n1 Plaintiffs argue that 28 U.S.C. @ 1447(d) precludes a district court from reconsidering an Order

remanding a case to the state court. Section 1447(d) states that, except for civil rights cases removed pursuant to 28 U.S.C. @ 1443, "an order remanding a case to the State Court from which it was removed is not reviewable on appeal or otherwise . . . " We read this language to preclude only certain appellate review of a remand order. Indeed, we have located four decisions wherein a district court entertained a motion for reconsideration of an Order remanding a case to state court. See e.g. State of Fla. v. Simanonok, 850 F.2d 1429 (11th Cir. 1988); Smith v. Anadrill, Inc., 762 F.Supp. 1267 (S.D. Tex. 1991); Knickerbocker v. Chrysler Corp., 728 F.Supp. 460 (E.D. Mich. 1990); Litka v. University Of Detroit Dental School, 610 F.Supp. 80 (D.C. Mich. 1985).

---------- End Footnotes ----------

Accepting the allegations in the complaint as true as we must when considering a Rule 12(b)(6) motion, the relevant facts are as follows:

Verzicco worked for a company that provided its employees with a U.S. Health Care benefits plan. n2 Once an employee chooses to become a member of this plan, the employee selects out of a directory provided by U.S. Health Care a primary care physician. The primary care physician supervises, coordinates and provides initial care and basic medical services to its members. The primary care physician also refers the member for specialist care and maintains the continuity of patient care. Defendant Dr. Leonard Harman was Verzicco's primary care physician. Verzicco had been under Dr. Harman's care since November of 1977.

----------Footnotes----------

n2 It is undisputed that this plan constitutes a "employee benefit plan" as defined by ERISA, 29 U.S.C. @ 1002(1) and (3).

---------- End Footnotes ----------

On July 30, 1990, Verzicco visited Dr. Harman's office complaining of chest pain, mild shortness of breath, and [*5] numbness in her shoulders lasting about twenty minutes. Dr. Harman measured Verzicco's blood pressure, which was 150/88, and took an electrocardiogram which revealed an abnormality in t-waves. Dr. Harman ordered blood tests and the use of a Halter Monitor. After approximately one day, Dr. Harman discontinued use of the Halter Monitor because he was told by U.S. Health Care that it would not pay for the service of the Halter Monitor. Dr. Harman did not read the results of the day Verzicco wore the Halter Monitor.

On August 14, 1990, Verzicco began experiencing chest pains radiating across her shoulders, down her arm and up her neck. She went to the Emergency Room at Parkview where she was examined by the attending physicians, defendants Robert McAndrew, M.D. and Dr. Potman. Verzicco's blood pressure was 180/110 and the doctors ordered an electrocardiogram which showed evidence of anterior wall ischemia or infarction. Verzicco was given medication and was directed to return if her condition worsened. She was also instructed to contact Dr. Harman on Thursday, August 16, 1990.

The following day, while driving her car, Verzicco experienced extreme chest pain and passed out. She was [*6] rushed to Parkview where prolonged resuscitative efforts were performed. However, Verzicco remained unconscious with cardiac arrest and to this day has not regained consciousness. Verzicco suffered irreversible anoxic encephalopathy, which is expected to last for the rest of her life. Verzicco remains at the Fox Nursing Home and Rehabilitation Center where she has been in a persistent vegetative state.

In their complaint, plaintiffs assert, inter alia, claims for negligence, misrepresentation, and breach of contract

against U.S. Health Care with regard to the treatment rendered to Verzicco by her primary care physician. In its motion for reconsideration, U.S. Health Care continues to insist that all three claims are pre-empted by ERISA and should, therefore, be dismissed. We will address all three claims in seriatim. But first a word about ERISA pre-emption in general.

The pre-emption section of ERISA, 29 U.S.C. @ 1144(a) provides in relevant part that " . . . the provisions of this subchapter . . . shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan . . . " In determining that a state common [*7] law claim for tortious breach of contract was pre-empted by ERISA, the court in Pilot Life Insurance Company v. Dedeaux, 481 U.S. 41, 47 (1987) described the inclusive nature of the pre-emption clause:

In both Metropolitan Life (citation omitted) and Shaw v. Delta Airlines, Inc., (citation omitted), we noted the expansive sweep of the pre-emption clause. In both cases 'the phrase '[sic] relate to' was given its broadest common-sense meaning, such that a state law 'relates to a benefit plan' in the normal sense of the phrase, if it has a connection with or reference to such a plan.' (citations omitted) In particular we have emphasized that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'

The court re-emphasized the broad scope of the pre-emptive effect of ERISA in Ingersoll-Rand Company v. McClendon, ___ U.S. ___, 111 S.Ct. 478, 482-83 (1990).

'The pre-emption clause is conspicuous for its breath [sic] (citation omitted).' Its 'deliberately expansive' language was designed to 'establish pension plan regulation as exclusively a federal concern (citation [*8] omitted).' The key to @ 514(a) is found in the words 'relate to.' Congress used those words in their broad sense rejecting more limited pre-emption language that would have made the

clause 'applicable only to state laws relating to the specific subjects covered by ERISA (citation omitted).' Moreover, to underscore its intent that @ 514(a) be expansively applied, Congress used equally broad language in defining the 'State law' that would be pre-empted. Such laws included 'all laws, decisions, rules, regulations or other state action having the effect of law.' 514(c)(1), 29 U.S.C. @ 1144(c)(1).

See also, The 1975 Salaried Retirement Plan for Eligible Employees of Crucible, Inc. v. Nobers, 968 F.2d 401 (3d Cir. 1992).

With those principles in mind, we now turn to plaintiffs' three state law claims to determine if indeed they are pre-empted by ERISA. We begin with plaintiffs' negligence claim. In that claim plaintiffs allege:

(i) All of the acts referred to above by all of the individual physicians and professional corporation physician, as well as, defendant Parkview, are imputed to defendant, U.S. Health Care, particularly [*9] since plaintiff, Verzicco, looked to U.S. Health Care for care and U.S. Health Care held out Dr. Leonard Harman, P.C. and Leonard Harman, M.D. as its employee. Verzicco justifiably relied upon the care and skill of Leonard Harman, M.D. based, in part, upon the assurances of defendant, U.S. Health Care, that Dr. Leonard Harman, P.C. and Leonard Harman, M.D., the primary care physician, were competent and qualified;

(ii) U.S. Health Care failed to exercise reasonable care in selecting, retaining and evaluating plaintiff's primary care physician and, as a result of its failure to use such reasonable care, the risk of harm to plaintiff, Verzicco, was increased resulting in the injuries and damages as set forth herein, thus, subjecting it to liability pursuant to 323 of the Restatement of Torts 2d;

(iii and iv) U.S. Health Care improperly instructed Leonard Harman, M. D. that it would not pay for the Halter Monitor causing him to discontinue its use after approximately one day and causing Dr. Harman to fail and refuse to read the results thereof, particularly when the continued use of the Halter Monitor was important for diagnosis and treatment based upon the complaints of Verzicco, and her history;

(v) Other acts of negligence of defendants, Dr. Leonard Harman, P.C. and Leonard Harman, M.D. pertaining to the medical treatment rendered to Verzicco.

Complaint at 41(c)1.

In our Memorandum Opinion of July 13, we found that all of the allegations in plaintiffs' negligence claim were predicated upon the negligence theory of "apparent" or "ostensible agency." Although an HMO is not usually liable for the negligence of the independent contractor physicians and health care providers that service the HMO members, an HMO may nevertheless be held liable if the health care provider is the "ostensible agent" of the HMO. Boyd v. Albert Einstein Medical Center, 377 Pa. Super. 609, 547 A.2d 1229 (1988). n3 At least with respect to paragraphs one, two and five of plaintiffs' negligence claim, plaintiffs are seeking to hold U.S. Health Care vicariously liable for the actions of Verzicco's primary physician acting ostensibly as an agent of U.S. Health Care. As such, the allegations contained in these paragraphs do not rely on obligations under U.S. Health Care's benefits plan, but on the principles of professional malpractice. [*11] See Kohn v. Delaware Valley HMO, Inc., C.A. No. 91-2745 (E.D. Pa. December 19, 1991) (Hutton, J); Independence HMO, Inc. v. Smith, 733 F.Supp. 983, 987-989 (E.D. Pa. 1990). Our Court of Appeals recently opined, in Painters of Philadelphia District Council No. 21 Welfare Fund v. Price Waterhouse, 879 F.2d 1146 (3d Cir. 1991), "that ERISA does not generally

pre-empt state professional malpractice actions." Id. at 1153, n. 7. In rejecting the argument that an implied cause of action existed under ERISA for medical malpractice claims, the Court of Appeals stated:

. . . state law has traditionally prescribed the standards of professional liability and, in the absence of clear indicia in the act or legislative history, we are reluctant to ascribe to Congress an intention to intrude in this area. Far from there being clear indicia of an intent to create an implied professional malpractice cause of action under ERISA, there is not a scintilla of evidence that Congress had this in its mind . . .

Id. at 1152-53. We, therefore, find that paragraphs one, two [*12] and five of plaintiffs' negligence claim are not pre-empted by ERISA.

----------Footnotes----------

n3 In Boyd, the Pennsylvania Court found that "the two factors relevant to a finding of ostensible agency are: (1) whether the patient looks to the institution, rather than the individual physician for care, and (2) whether the HMO "holds out" the physician as its employee." 547 A.2d at 1233. In paragraph one of their negligence count, plaintiffs specifically allege that "Verzicco looked to U.S. Health Care for care and U.S. Health Care held out Dr. Leonard Harman, P.C. and Leonard Harman, M.D. as its employee."

---------- End Footnotes ----------

The allegations in paragraphs three and four of plaintiffs' negligence count, however, present a different story. In those paragraphs plaintiffs allege that U.S. Health Care improperly instructed Dr. Harman that it would not pay for the Halter Monitor. Plaintiffs are not seeking to hold U.S. Health Care liable on a vicarious basis for acts of negligence allegedly committed by Dr. Harman while [13*] acting ostensibly as an agent of U.S. Health Care.

Rather, plaintiffs seek to hold U.S. Health Care directly liable, for refusing to pay for the Halter Monitor under its benefits plan. Such a claim for failure to provide funding clearly has a "connection with or reference to" a benefit plan. See Corcoran v. United Healthcare, Inc., No. 91-3322, 1992 U.S. App. Lexis 14621 (5th Cir. June 26, 1992). (Plaintiffs' claim that U.S. Health Care was negligent in failing to pre-certify payment for certain medical services held pre-empted by ERISA); Kohn, supra (plaintiffs' claim that the defendant HMO failed to provide finding to the plaintiff decedent's family for treatment that their own therapists prescribed for plaintiff decedent held pre-empted by ERISA). We, therefore, find that paragraphs three and four of plaintiffs' negligence count are pre-empted by ERISA.

Having found that all of plaintiffs' negligence claims with the exception of paragraphs three and four are not pre-empted by ERISA, we turn to plaintiffs' claims for misrepresentation and breach of contract against U.S. Health Care. In those clams [sic], plaintiffs allege:

(i) U.S. Health [14*] Care intentionally misrepresented that each and every primary care physician, including Leonard Harman, M.D. and Dr. Leonard Harman, P.C., satisfied criteria for participation as a qualified physician after passing vigorous screening criteria established by U.S. Health Care and the primary care physician with whom Verzicco enrolled under the terms of the contract with U.S. Health Care would perform all necessary medical care and treatment and any diagnostic tests which were necessary, including referring Verzicco to a coronary care unit or hospital, if necessary;

(ii) Verzicco relied upon the statements of U.S. Health Care which were intentionally false and misleading, and, as a result of her reliance, she sustained the injuries described herein;

(iii) The misrepresentations and fraudulent utterances were intended by U.S. Health Care to cause Verzicco to act by subscribing to U.S. Health Care as an HMO and Verzicco justifiably relied upon the misrepresentations with resultant damages as the proximate result thereof;

(iv) The misrepresentations, even if innocent by U.S. Health Care, relates to matters material to the choice and continued use of a health care provider by Verzicco [*15] since it was in such a character that if the misrepresentations had not been made, Verzicco would not have joined U.S. Health Care, or would not have chosen and continued to use Leonard Harman, M.D. as her primary care physician;

(i) U.S. Health Care through contracts and other documents that are within the possession of U.S. Health Care promised that the primary care physicians, including Leonard Harman, M.D., had to undergo vigorous screening and meet certain criteria to be qualified as a primary care physician for U.S. Health Care, and promised that Leonard Harman, M.D. did undergo this screening, met the criteria and was qualified as a primary care physician and that the patient would be referred by Leonard Harman, M.D. to appropriate specialists or hospitals as required for necessary medical treatment and Verzicco enrolled herself and her family with U.S. Health Care for all of her medical care and executed a contract with U.S. Health Care for U.S. Health Care to provide said medical care;

(ii) U.S. Health Care breached the provisions of the contract which required it to provide Verzicco with a qualified primary care physician to provide reasonably competent medical care, including [*16] appropriate referrals;

(iii) As a result of the breach, Verzicco suffered the injuries described herein.

Complaint at 41(c)2,3.

In our Memorandum Opinion of July 13, we lumped plaintiffs' misrepresentation and breach of contract claims with plaintiffs' negligence claim and found that all three claims attempted to hold U.S. Health Care liable in a vicarious capacity for the actions of Verzicco's primary care physician. Upon further reflection, however, we find that each of plaintiffs' three claims are separate and distinct from each other and must be considered individually.

As noted above, the nature of plaintiffs' misrepresentation claim is that U.S. Health Care misrepresented that the primary care physician with whom Verzicco enrolled under the terms of the contract with U.S. Health Care would perform all necessary medical care and treatment. This claim obviously has a connection with or reference to a benefit plan as it is based on representations over the extent of and nature of the care provided under the benefit plan. Plaintiffs' claim for misrepresentation is, therefore, pre-empted by ERISA. See Berger v. Edgewater Steel Co., 911 F.2d 922, 923 (3d Cir. 1990). [*17] (ERISA pre-empted state law claim for misrepresentation); Bernatowicz v. Colgate-Palmolive Co., 785 F.Supp. 488, 493 (D.N.J. 1992).

Plaintiffs' breach of contract claim is likewise pre-empted by ERISA. In that claim, plaintiffs allege that U.S. Health Care breached the provisions of the contract when it failed to provide Verzicco with a qualified primary care physician. Again, this claim obviously has a connection with a benefit plan, as it is based on an alleged contractual obligation under the benefit plan to provide for a qualified primary care physician. See Pane v. R.C.A. Corp., 868 F.2d 631, 635 (3d Cir. 1989); Kohn, supra.

The fact that ERISA may not offer a remedy for plaintiffs' pre-empted claims does not alter our conclusion. Although our Court of Appeals has not addressed the issue, the Courts of Appeals for the Fifth and Seventh Circuits have both held that a claim is still pre-empted under ERISA even if the plaintiff is left without a remedy. See Corcoran, supra; Lister v. Stark, 890 F.2d 941, 946 (7th Cir. 1989), cert. denied, 111 S.Ct. 579 (1990). [*18] See also Weir v. Northwestern National Life Insurance Company, 1992 U.S. Dist. LEXIS 9653 (E.D. Pa. July 2, 1992).

In sum, plaintiffs' claims against U.S. Health Care for misrepresentation, breach of contract and negligence (paragraphs three and four only) will be dismissed as pre-empted by ERISA. The remainder of the action, including the remainder of plaintiffs' negligence claim against defendant U.S. Health Care will be remanded to the Court of Common Pleas of Philadelphia County.

ORDER – October 1, 1992, Entered

The motion of the defendant U.S. Health Care Systems of Pennsylvania, Inc. for reconsideration is GRANTED in part and DENIED in part.

The motion of the defendant U.S. Health Care Systems of Pennsylvania, Inc. for certification is DENIED.

The Order of this Court dated July 13, 1992 is VACATED.

In its stead, it is ORDERED that:

The motion of the defendant United States Health Care Systems of Pennsylvania, Inc. to dismiss the complaint is GRANTED in part and DENIED in part.

The motion of the plaintiffs to remand is GRANTED in part and DENIED in part.

Plaintiffs' claims for misrepresentation, breach of contract and negligence (paragraphs [*19] three and four

only) against U.S. Health Care are DISMISSED as pre-empted by ERISA.

The remainder of the action, including the remainder of plaintiffs' negligence claim against defendant U.S. Health Care is REMANDED to the Court of Common Pleas of Philadelphia County.

Defendant U.S. Health Care is not responsible for plaintiffs' attorney's fees and costs as originally stated in our July 13 Order.

The Clerk is DIRECTED to mark this case closed.

IT IS SO ORDERED.

CHARLES R. WEINER